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		1	For Amend Items State Registrar	25,27,28	3a-I	per n	ertificate of	1721/2011 Death	dhb R	eg. No.	10	43001
	Physicia		1. Decedent's Name (First, Middle, Last)						2. Date of Deat Month	h Day	Year	3. Time of Death
i	Medic	al _	Anna Mae Vail 4a. Facility Name (If not institution, give stre	et and number)			4h City Town	or Location of Deatl	12	4c. County	2010	12:16 PM
5	Examin		Peninsula Reciona		(0	Her	4b. City, Town, C	Ilish Ir	-\/	1 L	OM	100
5	Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. las	t birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthpl	ace (State or Foreign
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/lan	Aental Aental Irked tic ev	卢	Angelo Lewis Not	tarfonz	0			1	Bertha			
Maryland	should and N is ma auma	Ī	19a. Informant's Name/Relationship (Type,	, Print)		19b. Ma	iling Address (Street	and Number or Ru	ral Route Number,	City or Town, St	tate, Zip C	,
e,	and 2 Health Yern 27 Ither t	-	Carryl M. Vail 20a Method of Disposition		20b Pla		Greenb	ackyill		tockto 20c. Location -		
mor	Page 1 nent of ant: If it iry or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ce	metery, cr	ematory or other pla tate Cr					
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, P.O.	igned be det	۾	Part II. Other significant conditions conti	ributing to death b	ut not resu	iting in the	underlying cause g	iven in Part I.				e cause of death?
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A	ay		30. Name and address of person who com	pleted cause of d	eath (Item :	23a) (Type	, Print)	1101 -11	// m \ \ /	-111	15 11 16	1 V 41 N 7 10 m
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** 0 0 /Medical 40 County of Death 4a. Facility Name_(If not institution, give street and number Town, or Location of Death Examiner 8. Date of Birth (Month, Day, If Under 24 Hrs. Birthplace (State or Foreign Country) last birthday Funeral Months Days Hours 1 M 2 □ F Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Posical Examinar must be nothed at 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Porces? 11. Marital Status 2 No 1971 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: þ 3 Widowed 4 Divorced 1976 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) is marked other than 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be ည Pages 1 and 2 should or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Department of Health ar Important: If item 27 is any Injury or other trauonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee RGMO Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) 7/Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 🗌 No 3 Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an autopsy performed? 1 Yes 2 No spital or Attending Physician: The hours after death.
Ineral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral E Medical 29a. Certifier Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person wh completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Redistrat's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death CCHD AS 1-409-1Nt Registra AMENDED ITEM#7 PER FH 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Mary Elizabeth Walls 26 Day 2010 Year Month Physician/ 6:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Ridgely 11570 Ridgely Road 8. Date 2 4 sirth 927 Wonth, Day, Year, 192 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Country) MD 1 M 2 F 83 218-24-5336 Director Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10c, City, Town or Location 10a. State 10b. County Director 1 X Yes 2 □ No MD Talbot Easton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21601 Funeral 7 Curzon Ct. death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 XNo Yes, Give þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced than "natural", Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Homemaker / school bus driver (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) ad family / education should be filed within and Mental Hygiene. marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Cora Green Samue1 Cosden Kimbles, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 11570 Ridgely, MD 21660 S. Kay Skinner / daughter 1 and 2 s of Health a item 27 i Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place)
Church Hill Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/31/10 Church Hill, MD 21. Signature of Funeral Service Ligense 22. Name and Address of Facility Moore Funeral Home, P.A., 12 S. 2nd St., Denton, MD 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cance Medical consequence of): to (or as Examiner Desease Wood or Sequentially list conditions uence of If any Inading to in mediate cause. Enter Underlying that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No 4 ☐ Pregnant 9 ☐ Unknown signed by the a Yes Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 ☐ No this certificate Yes 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Director: After 1 Natural 5 Pending injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Excritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) B.O. Phy (101A) 29d. Date signed (Month. 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Valarie Goodman, MD

31. Date filed (Month, Day, Year,

22. Registrar's Signature

2540 Centreville Rd., Centreville, MD 21617

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Beverly W. Weddle December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5201 Hayloft Court Frederick <u>Frederick</u> Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1av 2. 1927 1 M 2 X Months Days Hours Min May Director 219-20-4317 83 Maryland Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits must be notified at Director MD Frederick Frederick 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 5201 Hayloft Court 21703 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Force Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. white Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Colfege (1-4 or 5+) <u>secretary</u> <u>state government</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary C. Brubaker Ray Wisner 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Sabrina Pyle / daughter</u> 673 Taylor Mill Road, Ridgeland, S.C. 29936 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
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any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 12/30/2010 Smithsburg, MD 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service Licenses Julie MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician/ PANCEE 4 TIC disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Be Completed by Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N eral Director: After this certificate has filled in by the funeral director, page 2 1 Ves 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 1 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direc Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier WZ1936 melson 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOM 40 JOYNSON DR, FRE BERICK, MD 21702 65c DONE LUON MA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

32. Regist ar's Signature

Rosera

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month 12:01 Virginia December 29 2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Feb • 17 1 Birthplace (State or Foreign Country) 5. Social Security Number . Age (In vrs. last birthday) Min. Months Days Hours 215-42-4095 66 Feb. 1944 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Md. Montgomery Clarksburg 1 Yes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23737 Slidell Road 20871 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Restaurant Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Noah Compton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William B. Warfield / Husband 23737 Slidell Road, Clarksburg, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Brownsville Heights C. 1/4/2011 4 ☐ Donation 5 ☐ Other (Specify) Brownsville, Md. 21. Signature of Funeral Service Live 22. Name and Address of Facility
Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 00470 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

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permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any lnjury or other traumatic event, the Medical ones.

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Hospital or Attending

Division of Vital Records, P.O. Box 68760,

physician and as the burial-transit use as To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu

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Completed by Physician/Medical	Part II. Other significant conditions of renal failure Chronic Obstruct	<u> </u>				o use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Unknown} \) 24b. Were autopsy findings available prior to completion of cause of death? No 1 \(\text{Yes} \) 2 \(\text{No} \)
Be 0	25. Was case referred to medical			26. Place of De	eath (Check only one)	
TO B	examiner? 1 \sum Yes 2 \sum No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing I	Home 5 Residence	6 ☐ Other (Specify)
ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in	jury occurred
Sertifica	3 Suicide 6 Could not be determined		ome, farm, street, fact	ory, office	28f. Location (Street City or Town, Star	and Number or Rural Route Number, te)
Medical Certification:		nysician: To the best of my knominer: On the basis of examination and manner stated.				(s) and manner as stated. and place, and due to the cause(s)
Me	29b. Signature and title of certifier	7 fm	,	29c. License number RES - 000		Date signed (Month, Day, Year) ember 29 2010

Registrar

State

333 M

30. Name and address of person who completed

32. Regist ar's Signature

cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **28**^{Day} Month CYNTHIA B. WHEELER 2010 12:20 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TALBOT HOSPICE HOUSE EASTON TALBOT Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 017-20-5624 1 M 2 X F Yrs. 85 MASSACHUSETTS Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No **EASTON** MD TALBOT 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 117 EAST DOVER STREET USA 21601 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Force 1 Never Married 2 Married ☐ Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 AUTOMOTIVE OFFICE MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PHILIP DAVID BOGDONOFF NEILA PETERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID J. WHEELER, SON 28072 COVE COURT, EASTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State STEVENSVILLE, MD CHESAPEAKE CREMATION 12/29/2010 4 Conation 5 Cher (Specify) 22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
200 SOUTH HARRISON STREET, EASTON, MD 21 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one caus each line Death Immediate Cause (Final Pluch disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Day Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

law requires that the death certificate be executed physician and the burial-trans Division of Vital Records, P.O. Box 68760 as attending nse ę detached by pe peen this certificate : After s after de. •• Director: Afte completed filled in by To the Hospital within 24 hours a To the Funeral E

Physician/

Medical

Examiner

Funeral

Director

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23a

death v items

within 72 hours after

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Baltimore, Maryland 21215-0036

Examiner must be notified at

an "natural", or i Medical Examin

event, the

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al Hygiene.

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permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic

Physician/

Medical Examiner

Examiner

Physician/Medical

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Certificate: To

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29b. Signatur

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				1 □ Yes 2 0	No 3 ☐ Probably 4 ☐ Unknown
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?			26. Place of Death (Che	eck only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing I	Home 5 Residence 6	X Other (Specify) HOSPICE
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Speci		ory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
(Check 2 Medical Exami	sician: To the best of my knowiner: On the basis of examination se Practioner: To the best of r	on and/or investigation, i	n my opinion, death occurred	at the time, date and place,	and due to the cause(s) and manner stated

29d. Date signed (Month.

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TLS

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 3 2011

nd title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID H. SMITH 8221 TEAL DRIVE, SUITE 301, EASTON, MD 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar TCHD, 01/05/2011, TLS Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0923 A M **Physician** December 31 2010 GRACE FOSTER WATKINS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Memorial Hospital at Easton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Funeral Days Months Hours 1 □ M 2 🕱 F 02/09/1940 70 Director 044-32-2707 Usual Residence of Decedent 10d Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director ROYAL OAK TALBOT MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with UNITED STATES 21662 5161 ULMER ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING CORPORATE SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be 1 and 2 should be i Health and Mental JOANNE FOSTER FARGO HERBERT HASTINGS FOSTER, JR. 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HUSBAND 5161 ULMER ROAD, ROYAL OAK, MD 27 FRANK MOORE WATKINS, M.D. if item 27 or other t timore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Pages 1 CHESAPEAKE CREMATION CENTER ₽ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: if any injury or once. 01/05/2011 STEVENSVILLE, MD FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause ngt caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Immediate Cause (Final nedis varwlon hors MYOSCHOTIC **Physician** disease or condition resulting in death) ├─/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): of Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performe 1 ☐Yes 2 ☐No certificate 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∰No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation ours after death.

neral Director: A 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier TLS 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 12 503 CYNWOOD DR., EASTON, MD **EGL**SEDER MD LUDWIG J٨ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:05 PM Dovember Robert L. Wagner, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death Examiner 4c. County of Death BALTI HORE WASHINGHTON HEDICAL AACOUNT If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Y Days 1 **X** M 2 □ F Months Min. 82 214-26-2090 Director Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified Millersville MD Anne Arundel 1 Yes 2X No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a 8303 Brookwood Road 21108 USA **Examiner must** 'natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. by ☐ Yes 2 X No 1 Never Married 2 Married 1
☐ Yes :
If Yes, Give White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. 2121 United States Elementary/Seconday (0-12) College (1-4 or 5+) Naval Academy Lab Technician 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Edith Given Henry Leroy Wagner permit. Page 1 and 2 should I Department of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cyndi Gardner / Daughter 115 Horizon Drive Millersville, MD 21108 mportant: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 04, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State January Matro Crematory, INC. Baltimore, MD 4 Donation 5 Other (Specify) 2011 Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ CORONARY ARTERY - Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): -transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): the burialphysician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month 1 Yes 2 No 9 Unknown detached g Unknown þ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown FIBRILLATION 24b. Were autopsy findings available 24a. Was an this certificate has I autopsy performed? prior to completion of cause of death? page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ 1 Inpatient 2 FR/Outpatient 3 IDOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred : After Natural 5 Pending 1 🗌 Yes 2 🗎 No Accident Investigation s after death Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a To the Funeral L Hospital Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) DS 753 JANUARY 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mohit Nego 31. Date filed (Month, Day, Vear) 8601 Veterans 21108 State JAN 0 4 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 2010 1:43 AM Naomi T. Willett 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Edgewater 1506 Fullerton Road Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Month, Day, August 1 🗆 M 2 🕱 F Months Days Hours Min Cuba 83 14, 192 265-42-4902 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Marvland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1506 Fullerton Road 21037 Was Deceus.
Armed Forces?
Vas 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 ☐ No Specify: If Yes, Give Year or Dates 3 ☐ Widowed 4 🛣 Divorced Cuban Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hote1 Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zola Diaz Vincent Balle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1506 Fullerton Road, Edgewater, Maryland 21037 Gwendolen D. Willett/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Sign 1///// Une Servi Licensee 12/29/2010 Kalas Crematory Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home Service Licensee 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic Cancer disease or condition resulting in death) Due to (or as a cons once of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death Day Year g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Ph_sician/ Medical Examiner

the attending physician and ned for use as the burial-trans

been signed by the should be detached

this certificate has raidirector, page 2 s

24 hours after death Funeral Director:

Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Exam

Physician/Medical

Completed by

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Certificate:

IF FEMALE:

Physician/

Medical

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Director

Funeral

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Examiner

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Director

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iral", or items 23a or 28a-f sho Examiner must be notified at

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and Mental Hygiene. is marked other than

permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once.

the Medical

72 hours after death

Maryland 21215-0036

Baltimore,

Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ¥ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

1 Yes 2 No

25. Was case referred to medical examiner? Hospital 2 No 1 Tes Manner of Death

1 Natural

only one)

29a. Certifier

Accident

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year)

4 Nursing Home 5 Residence 6 Other (Specify, 28b. Time of 28c. Injury at injury 1 Tes 2 No

Other:

28d. Describe how injury occurred

performed? Yes 2 No

3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Hava Hones

5 Pending

Investigation

D052023

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only one)

Srute 122

Annapolis, Md 20639

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIA ROMERO M.D Depene 122 31. Date filed (Month Ray)

2011

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Walters Kamerine Year 08:45 AM December 2010 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Seasons Inpatient Hospice Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 252-03-6119 March 25 Year 1913 97 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Catonsville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6348 Frederick Rd. 21228 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 X No 14. Race - American Indian. Completed by Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator Bell Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlie Maddox Sybil Keester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Walters - SON 1608 South Alamo Rd., Rockwell, TX 75087 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Cedar Hill Cemetery Jan. 4, 2011 Brooklyn Park, Maryland 21. Signature of Funeral Service Licensee Fleck Funeral Home. INC. MO123 7601 Sandy Spring Rd., Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Atheros clerchic ardivascular disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated as of the cause). Due to (or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Cectopic pregna 5 Other (specify) Ectopic pregnancy Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed/ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 □ Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) - Party nt hapite 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Physician/ -Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours all er death attending physician and for use as the burial-transi Division of Vital Records, P.O. Box 68760 ed by the a ate has been signed I page 2 should be det 24 hours all er death Funeral Director: After this certificate has

Examine Physician/Medical þ Completed completed filled in by the funeral director, Be မ Certificate:

Physician/

Examiner

Funeral

Director

notified at

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an "natural", or items 23a o Medical Examiner must be

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permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical

To the within 2

State Registrar

Medical

MS (Ca) Aprilme MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DDUS7465

1 Tes

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 12/29/10

Location (Street and Number or Rural Route Number, City or Town, State)

N-5. Raynpaker M.D

2835 Smin N- S-203 Baltimore, MO. 21209

31. Date filed (Month, Day, Year) JAN 03 2011

29b. Signature and title of certifier

5 Pending

Investigation 6 Could not be

determined

1 Natural

Accident

Suicide

4 Homicide

only one)

29a. Certifier

32. Régistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

WILLIAMS, ERNEST

			Plea	se Type or Pri							Legible.	
		_	For State	State of M	arylan		artment of I <i>tificate of L</i>	Health and I	Mental Hy	/giene	0010	0011
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	illicate of L	Jeauri	2. Date of De	Reg. No.	ZUIU	3. Time of Death
Phys Me	iciar edica		Ernest Williams	5					Month	23	2010	
Exa	mine	er	4a. Facility Name (if not institution, COASTALHO	give street and number) SDICE AT T	HEL	AKE	4b. City, Town, o	r Location of Death	٦'		County of Deat	MICO
Fune Direct			5. Social Security Number 255–98–0322	6. Sex 1 ★ M 2 ☐ F	e (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da Apr 8		9. Birt	hplace (State or Foreign untry) GA
d wo			Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Lo	eation					10d. Inside City Limits
larylan ka-fsh ified a		Funeral Director	MD Worce	ester		ow Hi]						1X Yes 2 □ No
the N		٥	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Co	untry?
th with ms 23		ner	500 Maple St.,				2186				USA	
Baltimore, Maryland 21215-0036 semit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		<u>ا ۾</u>	11. Marital Status 1 □XNever Married 2 □ Marri 3 □ Widowed 4 □ Divorced	12, Was Decedent 8 Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.			Vas Decedent of H f Yes, specify Cuba □ Yes 2 🙀 No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecity Yes or No o Rican, etc.)			
15-0 2 hour "natu		Completed		t's Education st grade completed)		(Give I		during most of wor	king	16b. Kir	nd of Business	Industry
vithin / liene.		ဦ	Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. Di	O NOT use retired) Disable				n/a	
nd 2 filed v al Hyg d othe		Be	17. Father's Name (First, Middle, La					18. Mother's Nan		, Maiden S		
ryla uld be d Ment marke		၉	Wallace William					Sarah M				
Ma 12 sho llth and 27 is r			19a. Informant's Name/Relationsh Myra Biggins/ac				,	and Number or Rule, Apt. 1.				
		1	20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation			lace of Dispo	sition (Name of natory or other place	ce)	Date	T	cation - City or	
Baltimor permit. Page 1 Department of I Important: If it any injury or o			4 Donation 5 Other (S)	pecify)	1	ematory	of Delm	arva 1/06	5/2011	Del	mar, DE	<u> </u>
Bal permit Depar Impo	ouce,	-	21. Signature of Funeral Service Li	censee		22 I	Name and Addre	ss of Facility Watson Fi Rd., Sa	uņeral 1	Home,	PA	
			23a. Part 1. Enter the disease, or shock, or heart failure. List or	complications that caused	the death	n. Do not ente	or the mode of dyin	Rd Sa ng, such as cardiac	or respiratory a	rrest,	21801	Approximate Interval Between
Physicia	_	-	Immediate Cause (Final disease or condition	any one cause on each mic	Co	LON		CANCE	R			Onset and Death
Medic Examir	_		resulting in death)	Due to (or as a	consequ	rence of):						
		je	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequ	ence of):						
executed an and rial-transit		Examine	Cause (Disease or linjury that initiated events	c								
be exer bician a burial-d	- 11		resulting in death) Last	Due to (or as a	a consequ	ience of):					-	
certificate be nding physici use as the bu		Vedic		d								
Box death he atte ed for		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗌 Feta	Ideath 3	Ectopic pregnand Other (specify)	су		2	23d. Date of del Month	ivery Day Year
P.O. that the ned by the e detach	i	by P	Part II. Other significant condition	ns contributing to death b	ut not resi	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
cords, law requires as been sign		ted			_				1 🗆	Yes 2		robably 4 Unknown
Kecords, The law requires ate has been sig	ľ	Completed							24a. Was auto			topsy findings available completion of cause of
I Ke In: The I ifficate h or, page		Be Co	25. Was case referred to medical				26. P	lace of Death (Chec	1 🗌 Yes	2 No	1 ☐ Yes	2 D NO
ک بخر نقر آن		10 B	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆	ER/Outpatier	Oth	er:		idence 6	Other (Spec	ify)
on of Vital Fiding Physician: Tem. Tem. Tem. Tem. Tem. Fafter this certifical funeral director, p. 1000 pt. 100			27. Mann⊸ of Death 1 ☑ Natural 5 ☐ Pending			28b. Time of injury	28c. Injur work	₹?	28d. Describe	how injury	occurred	
DIVISION OF tal or Attending Ples after death. al Director: After the or by the funeral		Certificate:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place of Inju			M 1 L	Yes 2 □ No			Number or Rui	ral Route Number,
DIV ital or irs afte al Dir		- 1		building, etc				h.	,	wn, State)		
Hosp 24 hou Funer		Medica	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of ex	kamination	and/or invest	igation, in my opinio	on, death occurred a	at the time, date	and place,	and due to the	cause(s) and manner stated.
DIVISION OF To the Hospital or Attending P within 24 hours after death. To the Funeral Director; Affer the completed filled in by the funeral			only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	Jesi Oi My	MIOWIEGGE, C	29c. License		ice, and ade to t		and manner as	
D			Mah	wit	/	40	D6	50515		12	24/1	0
SV	1		30. Name and address of person w	the completed cause of delay 14 14 PMA	eath (Item	23a) (Type, P	rint) ASTIN IN	1 SHARC	DIA G	SAI	SKIJEY	M) 2/804
	State	-	31. Date filed (Month, Day, Year)	32/ Registra	r's Signat	ure		7/10-6	VI , -	10/	10001	-11 -(130-
Regi	stra	r	JAN 0 6 2	VIII Clerana	/ B	ba	Kar					

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		•	For State Registrar	State of	iviai yiai	•	tificate of E		and iv	Cittairiy	Reg. No			
			1. Decedent's Name (First, Mic	ddle, Last)		-				2. Date of De			3. Time o	f Death
	Physicia Medic		Lloyd Fern							13	2	5 2010		123M
	Examin	er	4a. Facility Name (if not institut			(0.010	4b. City, Town, or	Location	of Death	(1	4c.	County of Death	nico	
	Funeral		Poninsula Re 5. Social Security Number	76. Sex 12 M 2 □ F	. Age (In yrs.	last birthday)	If Under 1 Year		r 24 Hrs.	8. Date of Bir	th .	9. Birth	place (State o	or Foreign
	Director		222-26-6395	1 X □M2□F	67	7 Yrs.	Months Days	Hours	Min.	6-9-1	943	9. Birth MD ^{Cou}	ntry)	
	nd now at	_	Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. Ci	ty, Town or Lo	cation						10d. Inside C	ity Limits
	farylar 3a-f sl	ecto	MD Wic	omico	Sal	lisbur	У						1 X Yes	s 2 🗆 No
	the M	اق	10e. Street and Number				10f. Zip Code				_	izen of What Cou	ıntry?	
	h with ns 23e	Funeral Director	703 Edgewat				21804			1	USA			
Baltimore, Maryland 21215-0036	filed within 72 hours after death with the Maryland tal Hygiene. So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	호	11. Marital Status 1 ☐ Never Married 2 🔀 N 3 ☐ Widowed 4 ☐ Divord	If Ven Chin	es? X No	1	Vas Decedent of Hi f Yes, specify Cuba □ Yes 2 🔀 No			cify Yes or No- Rican, etc.)		14. Race - Ameri Black, White Specify Blac	, etc.	
2-0	2 hour "natu edical	Completed		edent's Education ghest grade completed)		(Give I	ient's Usual Occupa		st of workir	ng	l .	ind of Business Ir	ndustry	
12	thin 7 ene. than he Me	Sem	Elementary/Seconday (0-1:		or 5+)		ONOT use retired) k Drive:	r			I	rdue insport	ation	
2	lled w I Hygi other ent, t	Be	17. Father's Name (First, Middl	le, Last)		12200			ner's Name	(First, Middle,		_	acron	
Vlar		욘	Lloyd White	e, Sr				Nao	mi H	art_				
Jar	ar is		19a. Informant's Name/Relation				ng Address (Street a							MD 21
e,	and Healt em 2		Brenda Whit	ce/Wife	20b.	Place of Dispo	Edgewat	- :		Apt I		ocation - City or 1		MD 21
nor.	age 1 ent of nt; If ii ry or c		1 Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe	on 3 Removal from S	toto	cemetery, cren	natory or other plac ai Bapt	e) Cem	_			•		
alt	permit. Page 1. Department of I Important: If it any injury or o'			e Lice/ee			. Name and Addres							
m	P E E E	1	1100	Cal, 2	গ্ .	lp	uneral 1	Home	Sal	<u>ısbur</u>	У, Г	4D 2180	1	- 7
	Pnysician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	st only one cause on eacl	as a conseq	ric S	SHOCK		N/P				Approxima Interval Ber Onset and	tween
20	certificate be executed nding physician and use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	S c.	as a conseq									
200	death cerl ne attendii ed for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2 ☐ Fet ntat time of	al death 3 🗆	Ectopic pregnanc Other (specify)	у				23d. Date of deli		Year
7. Ö	law requires that the nas been signed by the 2 should be detach	by P	Part II. Other significant cond	litions contributing to dea	th but not re	sulting in the u	nderlying cause giv	en in Part	t I.			se contribute to		
ďs,	equires een sig ould b									1 🗆	Yes 2	□ No 3 □ Pro		1
DIVISION OF VITAL RECORDS,	The law ate has page 2	Completed								1 🗆 Yes	psy ormed?	death?	opsy findings ompletion of d	
Ita	sician certifi irector	m	25. Was case referred to medic examiner? 1 □ Yes 2 □ No	Hospital:		ER/Outpatier	Othe	ar:	ath (Check		dones 6	Other (Specif	6.0	
0	g Physer this leral d	ie: To	27. Mannar of Death	28a. Date of		28b. Time of injury	28c. Injury	/ at		8d. Describe			<i>'y)</i>	
o	endin sath. or: Aft he fur	lical		estigation	Day, reary	linjury	M 1 🗆	Yes 2	□No					
DINIS	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification completed filled in by the funeral director, to the funeral director.	al Certificate:	4 Homicide dete	ermined building	, etc. (Specif	y)	eet, factory, office			City or To	vn, State)			ber,
	Hosp 24 hou Funel eted fil	Medical	(Check 2 Medica	ing Physician: To the bes	of examination	on and/or invest	igation, in my opinio	n, death o	occurred at	the time, date	and place	, and due to the ca	ause(s) and ma	anner stated.
	To the within To the comple	Σ	only one) 3 L Certify 29b. Signature and title of cert	ing Nurse Practioner: To			29c. License	number			29d. Dat	te signed (Month,		
			Ma				D001	6698	46		121	27/10		
	Kar		30. Name and address of person		of death (Iter	m 23a) (Type, P	D001	/	1	in	1_0	0151-		
	200		MIRZA S. IZA: 31. Date filed (Month, Day, Year		istrar's Signs	CAILIO	LL ST. ?	RAli.	Sbun	24, M	ac	21801		
	Stat Registra	_	LAN O	4 2011	istrar's Signa	B. 10	arke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2344 PM Physician/ Vincent Keith Ward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOMICO Peninsula Reaional Medical Cente . Date of Birth Country) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 42 Director 23-60-7355 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medi-al Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Salisbury Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21804 111 Jenkins Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐XNo Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 X Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Spe Mack Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) McDonald' Restaurant 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic Jav Williams <u>Barbara Ward</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NY 10475 Barbara Ward/Mother Alcott Avenue, Bronx, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 112/27/2010 Westover, 4 ☐ Donation 5 ☐ Other (Specify) Macedonia Mem Pk 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Signature of Fun once. Salisbury, Funeral_Home 23a. Part I limfer the ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or em failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIOMYOPAT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 W No 24a Was an the Hospital or Attending Physician: The law autopsy performed' Be 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Other: 2 DM0 1 Tes 1 Inpatient 2 ER/Outpatient 3 I DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28b. Time of Medical Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 60515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASTERN SHUKE State Registrar

10-1	10091	
.lon	Boyd	Wise

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

on Boyd Wise		1- For State	tate of Maryla	•	artment of		and Mer	ntal Hy	_	Reg. No. 20	0	43014
Physicia	an/	Registrar 1. Decedent's Name (First, Midd							2. Date of Dea	ath		Time of Death
Medical Exami	ner	Jon Boyd 4a. Facility Name (if not institution		imber)		4b. City, Town	or Location	of Death	Decembe	Day Yea er 30, 2010 4c. County o		0038 hrs
		4615 Powder Mill Roa		imber)		Beltsville		Of Bodan		Prince G		
Funerai		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1	_	er 24Hrs.	8. Date of B	irth(MM/DD/YYYY	9. Birthpla	ace (State or
Director		213-84-3427	1XM 2_F	47	Yrs		Days Hour	s Min.	02/23	/1963		Yngton, DC
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ınd show any nce.												Yes 2 X No
rylanc a-f sh	휭	10e. Street and Number	e George's	з ре	ltsvill	.e 10f. Zip Cod	le		—-т	10g. Citizen of Wh	nat Country	?
ith the Maryland 23a or 28a-f sho notified at once.	Director	4615 Powder M	ill Road			2	0705			U.S	.A.	
with with be not		11. Marital Status		cedent Ever in U.		s Decedent of es, specify Cu			ecify Yes or N	o- 14. Race White		Indian, Black,
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rs after aral",	<u>a</u>	3 X Widowed 4 Div 15. Decedent's Education (Spe	vorced If Yes, Give Yea or Dates:		1 16a. Deceder	Yes 2 X			ork done	Specify: 16b. Kind of Bu		ite
5-0036 led within 72 hours tygiene. other than "natur	Completed	Elementary/Secondary (0-12)				ost of working						
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2121 Muld be fil Mental I marked	To Be	John Fra: 19a. Informant's Name/Relations		se	19b. Mailing	Address (S		rol		urdevant mber, City or Tow	n, State, Zir	p Code)
imore, MD 2 Pages I and 2 shou ment of Health and N saut: If item 27 is n or other traumatic		John F. Wise,		ner	10.7					wn, MD 20		
Te, M I and 2 Health ?		20a. Method of Disposition 1 Burial 2 X Cremation		20b. F	Place of Dispos		cemetery,		Date	20c. Location -	City or Tov	⊮n, State
MOI Pages lent of int: If		4 Donation 5 Other S		om State Met	tropoli	tan Cre	emator	01/	02/11	Alexand	ria,	VA
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr		21. Signature of Funeral Service								neral Hor		.A.
	-	23a. Part I. Enter the disease, or	7 / w	aused the death	Do not enter the	325 Mt.	Harmo	ny L	ane, Or	wings, MI	D 207	736 Approximate Interval
Physician /Medical		failure. List only one cause	on each line.	iac Arrh		ic mode of dy	ing, sacras	our dido or	roopiiatory at	root, ortoot, or riot	"` [f	Between Onset and Death
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lox 68760, eath certificate be attending physic for use as the bu	ian/	23b. Was decedent pregnant in the past 12 months?	I LIVE D	oirth ant at time of de	ath -	tal death	3 Ectop	c pregnar	псу	Month	Day	Year
Box 68760 e death certificate b the attending physical ed for use as the bu	Physician/Me	1 Yes 2 No 9 Un	known 9 Unkno		ot 5 Ot	her (Specify)						
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F. P.O ires that the signed by	Q P					_			1 Ye	s 2 No 3	Probabl	ly 4 🗹 Unknown
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Reco The law icate has	Completed by								1 ✓ Yes		leath? ✓ Yes	2 No
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oding Phath. Tr. After the funeral	tion	1 X Natural 5 Pend	ding	, Day,Year)		1[Yes 2] No				
Division of Vital Records, bostital or Atteoding Physician: The law requiring and a steer death. Journal Director: After this certificate has been signified in by the funeral director, page 2 should the filled in by the funeral director, page 2 should the filled in by the funeral director, page 2 should the filled in by the funeral director, page 2 should the filled in by the funeral director, page 2 should the filled in by the funeral director, page 2 should the filled in by the filled in by the funeral director.	Certification:		stigation 28e, Place	e of Injury - At ho	ome, farm, stree	et, factory, offic	ce building, e	tc.	28f. Location (er or Rural f	Route Number, City
Spital nours a oceral 1	9	4 Homicide dete	ermined (Specify)									
Division of Vital Records, P.O. Box 6876C To the Hospital or Atteoding Physician: The law requires that the death certificate within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the bill the funeral director, page 2 should be detached for use as the bill the funeral director, page 2 should be detached for use as the bill the funeral director, page 2 should be detached for use as the bill the funeral director, page 2 should be detached for use as the bill the funeral director.	Medical		hysician: To the bes miner:On the basis of	of examination ar								ause(s)
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		Carol	Hall	lac		0.	C.M.E.			December	30, 2010)
	ŀ	30. Name and address of person										
			sistant Medical	Examiner Signatu		imore Stre	et, Baltim	ore, ME	21223			
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year 1 FON M Physician/ Month 3.LLIUTT EZEKIAH 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. Country) Maryland Davs Hours 578-34-8202 Months 83 Director Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Tyes 2 No Calvert Broomes Island Maryland 1 4 1 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ò Funeral 23a United States 20615 8535 Patuxent Ave. items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seafood Waterman Be any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Mary Parks Hezekiah C. Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katvh Lvnn Elliott / Daughter 2804 Brite Ct., Crofton, Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🏋 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/31/2010 Asbury Cemetery Barstow, Maryland 22. Name and Address of Facility Rausch Funeral Home, PA. Signature of Funeral Service Licenses 4405 Broomes Island Road, Port Republic, Maryland 20676 Kyle S. Simons MO1206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23d. Date of delivery 23h. Was decedent pregnant in the past 12 months? Month Day Year signed by the a Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed? 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital Other: 1 Yes 2 No ၉ 1 patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 arrho the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner only one Signature and title of cert 29c. License number Name and address of pekso who completed cause of death (Item 23a) (Type, Print) NNAPOLIS MOUPDI 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 29 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12/27/2010 CHARLES 11:35 A M Medical BROOKS 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 3619 LAUREL VIEW COURT LAUREL Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mecaniesville, 8. Date of Birth Days Hours Min. 1 M 2 D F Months 3/4/1933 Director Yrs 579-46-9654 Usual Residence of Decedent or 28a-f show be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Director 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a o Examiner must be Funeral 900 G Street NE 20002 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Specify: Black th and Mental Hygiene.

27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative DC GOvernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ၉ Charles Brooks Rosa Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Woody / Daughter 3619 Laurel View Court Laurel, Maryland 20724 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ouantico National 1/7/ 2011 TRiangle, Va. 21. Signature of Funeral Service L 22. Name and Address of Facility Pope Funeral Homes, P.A. 40108 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death -arcinoma disease or condition **⊭** Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Pregnant at time of death Month Year signed by the a d be detached f 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗆 No Yes 2 No 25. Was case referred to medical funeral director æ 26. Place of Death (Check only one) Daughter House 2 2 No 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending ours after death.

neral Director: A
filled in by the fu Accident Suicide Investigation
6 Could not be 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 29c. License number M-1) MD037511 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) agnum Ba asubramanam 31. Date filed (Month, Day, 32. Registra

DHMH 17 Rev 7/2009

State

Registrar

JAN 0 5 2011

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		_	1- For State Registrar	Cert	ificate of	Death		F	Reg. No.		
	Physici		Decedent's Name (First, Middle,Last)					Date of Dea Month	Day	Year	3. Time of Death
Medic	al Exam	iner	JUSUE AID	erto Angel	14	0 T	Laurian of Door	Decembe		10	0715 hrs
			4a. Facility Name (if not institution, give st Prince George's Hospital Cer	•	41	c. City, Lown, or Cheverly	Location of Deat	n		county of Death	
	E		5. Social Security Number 6. Sex	7. Age (In yrs. las	st hirthday)	If Under 1 Yea	r If Under 24Hr	s 8 Date of Bi			hplace (State or Foreign
	Funeral Director					Months Day		_		, Cou	intry)
	311.53.53			2 F 29	Yrs.			11-19	1-190	¹ E1	Salvador
	any		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Locatio	n					10d. Inside City Limits
	. A		MD Prince Ge	Ta:	ur e 1						1 X Yes 2 No
	Maryland 28a-f show I at once.	햟	MD Prince Ge 10e. Street and Number	orges La	urer	10f. Zip Code		<u>T</u>	10a. Citize	n of What Cour	try?
	e Mai or 28	Director		C		20724				alvador	•
	rith th		3373 Sudlersville	D • 2. Was Decedent Ever in U.S.	13 Was		spanic Origin? (S				can Indian, Black,
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married	Armed Forces?			, Mexican, Puerto			White, etc.	
	fter d		3 Widowed 4 Divorced If Y	es, Give Year	1 🗓 🔻	Yes 2 No	specify: Sa1	vadoran	Sp	pecify: Hisp	anic
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	72 bc	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mos	st of working life	. DO NOT use ref	irea)		. Newco	
036	nthin 72 ene. or than	Completed	llth		Electr				1	ctric I	nc.
21215-0036	Hygid		17. Father's Name (First, Middle, Last)				18.Mother's Nam				
12	l be fi ental arked vent,	Be	Unknown				Delia Es				
	should nd M	7	19a. Informant's Name/Relationship (Type				et and Number or .11e S. I				
Q.	nd 2 salth a sem 27		Nancy Aldana 20a. Method of Disposition	• •		on (Name of cer		Date		cation - City or	
e e	of He		1 X Burial 2 Cremation 3	Removal from State	ematory or other	Cemeter	,		1		
Ĕ	Pag ment tant: or of	Ш	Donation 5 Other Specify:					-05-11		ago, Il	
Baltimore.	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med	1	21. signature of Funeral Service Licensee	APPELO	22. Na	me and Address	of FacilitW . H	Bacon	Fune	ral Hom	e, Inc.
		- (23a. Part I. Enter the disease, or complicat	ions that caused the death. D	344	/ 14th	St. N.W.	Washin or respiratory an	gton,	DC 200)] () Approximate Interval
	hysician Magical		failure. List only one cause on each li	ine.		inodo or dying,		n respiratory and	000, 011001	,	Between Onset and Death
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			b	to (or as a consequence or)s							
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	ansit 2		events resulting in death) Last Due d.								
	ate be executed physician and he burial - transi	Medical		MENDED							_
90	cate be ex physician he burial	Med	IF FEMALE: 2	3c. If yes, outcome of pregnar	ncy				23d. [Date of delivery	
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Box 687	leath certific e attending p for use as tl	Sici	1 Yes 2 No 9 Unknown	Pregnant at time of death Unknown	h 5 Othe	er (Specify)			1		
	the de	Physician/	Part II. Other significant conditions con		ulting in the und	derlying cause o	iven in Part I.	23e. Did to	obacco use	e contribute to t	he cause of death?
O. O.	ires that the signed by t is be detache	Ď	THE SERVICE WAS DOLLARS OF					1 Ye	s 2 N	lo 3 Prob	abiy 4 🗹 Unknown
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<u></u>	Phys rer this eral di	5	1 ✓ Yes 2 No 27. Manner of Death	- i inpationt 2 🕒 Li	8b. Time of Inju		y at Work?	28d. Describe			
Division of Vital Records,	nding P. th. r: After se funera	Ö	1 Natural 5 Pending	(Month Day Year))331 hrs	1 1	es 2 ✓ No	Subject sho	t		
<u>:8</u>	er dea	ica	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	e, farm, street,	factory, office b	uilding, etc.	28f. Location (Street and	Number or Rur	al Route Number, City
Š	ital or	Certification:	Suicide 6 Could not be determined	(Specify) Gas Station				or Town, S 3460 Laurel F	State) ort Mead	le Road , Lau	rel , MD
	Hosp 24 hou Fune tely fi		00- O-+if	To the best of my knowledge,	, death occurre	d at the time, da	ite and place, and	due to the caus	se(s) and n	nanner as state	d.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the state of the funeral director, page 2 should be detached for use as the funeral director.	Medical		the basis of examination and/ manner stated.	or investigation	n, in my opinion	death occurred a	t the time, date	and place	, and due to the	cause(s)
	1	ž	29b. Signature and title of certifier		<u></u>	29c. License	e number			te signed (Mon	
	3		Theodore U.	Kind The	w. A.	O.C.1	M.E. 00	ME	Decer	mber 29, 20	10
			30. Name and address of person who comp								
			Theodore M. King, Jr., MD.	Assistant Medical Exa		00 W. Baltim	ore Street, B	altimore, Mi	21223 ر	·	
	St	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	backe						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U 1- State 01 Maryland Registrar Amend#10e.PerFHPGCcr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Baker Month ancy 75/58/5070. 21:52 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Fort Washington 10800 Indian Head Highway If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-15-1917 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days Hours VA Director 71 231-22-4423 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Fort Washington 1 X Yes 2 No Prince George's MD 10e. Street and Number 10800 10f. Zip Code 10g. Citizen of What Country? Funeral Indian Head Highway 20744 AZU within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d 2 should be filed within 72 alth and Mental Hygiene.
127 is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Infant Clothing Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nannie Clayburn Eddie Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12000 Riverview Rd. permit. Page 1 and 2 sl Department of Health a Important: If item 27 i any injury or other tra Evangeline Murphy / niece Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 01/04/2011 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signa ure f Funeral Septice Licens 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd - Camp Springs - MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between atheroscleroti Immediate Cause (Final disease or condition Onset and Death Physician/ cardiovascular disease veacs Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). attending physician and frruse as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Bax 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Day Year ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 2 No 1 Yes Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) higgman no 02500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0161TAL DRIVE LINTHICUM 705 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carol Ann Bidwell December 2010 9:05 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 TF (Month, Day, Year Director 215-44-2810 1945 Washington, DC 65 Yrs. Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland St. Mary's Mechanicsville 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29849 Therese Circle 20659 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 X Divorced Specify: Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired)

Security Specialist permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Daun Larsen Helen L. Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Burns/Son 29849 Therese Circle, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 1/7/2011 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem. Charlotte Hall, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 30195 Three Notch Rd., Charlotte Hall, MD 20622 Approximate Interval Between Onset and Death Immediate Cause (Final £hysician/ Due to (or as a consequent e of) fail-re disease or condition Medical resulting in death) Examiner myocardial Infarction MINALLY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Dus to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last disease Due to (or as a consequence of) signed by the attending physician and deed detached for use as the burial-trans arkey Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Pregnant at time of death Unknown Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Hypertension Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Arthma 24a. Was an The law 24 hours after death. Funeral Director: After this certificate has autopsy perform 1 Yes 2 No ☐ Yes 2 🔼 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ျှ Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2/24/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leanard town, MD 20650 Point Lookout 25500 Rd Jerony D. Tucke 31. Date filed (Month, Day, Year) State gistrar's Signature JAN 0 4 2011 Registrar

Siduelly

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 1 20 10 Ursula E. Baker December 4:30 AMMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FutureCare Pineview Prince George's Clinton 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 8/28/1907 Months Days Hours Country) Arkansas Director 103 411-16-4934 Isual Residence of Decedent show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Clinton 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9106 Pineview Lane 20735 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify: Black Completed 3 ₩ Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) unkown Domestic Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) unk မ James Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Sanya C. Ham / Great Niece 62 Harborton Lane Fredericksburg, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/7/11 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fune 22. Name and Address of Facility Fort Lincoln Funeral Home Kega ances 3401 Bladensburg Rd. 20722 Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final 3 Onset and Death €nysician/ disease or condition Geriatric Failure to Thrive Medical resulting in death) Due to (or as a consequence of) Examiner 30 yrs Hypertension Sequentially list conditions, ne if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami and that initiated events resulting in death) Last Due to (or as a consequence of): the burial the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 1 ☐ Yes ∠ ₪ 9 ☐ Unknown Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? <u>Advanced Age</u> 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗓 No 1 Tes Other: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after deam.
al Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🔾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of gertif 29c. License number 29d. Date signed (Month, Day, Year) D0042049 January 4, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14314 Old Marlboro, MD Alain Champaliou, MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

JAN 0 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hazel Margaret Bell 1:30 2010 AM Medical <u>December</u> 30 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6315 Sligo Parkway Hyattsville Prince George's Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 ☐ M 2 🖾 F Months Days Hours **Director** 215-20-3593 86 September Hyattsville, MD Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ems 23a or 28a-f sh r must be notified a Maryland Prince George's Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6315 Sligo Parkway 20782 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed 3 ☒ Widowed 4 ☐ Divorced If Yes, Give Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Private Accounting Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Benjamin R. Gist Bernadine Lauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Bell / Son 13680 Oakland Road, Ridgely, MD 21660 Department of Heall Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 1/5/2011 Brentwood, Maryland 21. Signature of Fuzeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death

2 Weeks Pnysician/ Cerebral Vascular Accident Weeks Medical resulting in death) Due to (or as a consequence of): Examiner Atrial Fibrillation Years Sequentially list conditions, in the light conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 as the t IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ō in the past 12 months? 5 Other (specify) Pregnant at time of death Month Year Yes 2 X No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires Breast Cancer Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen Vascular Dementia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed' death? certificate 1 ☐ Yes 2 🔀 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 🔀 Residence 6 🗌 Other (Specify) 2 🕱 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

Parental Director: Af pleted filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical within 24 hor To the Fune completed fil 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number Sulliams, DO Cimthia M D033299 1/3/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Williams 3720 Upton Street N.W., Washington, DC 20016 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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	Examir		,	_	ve street and number)			4b. City, Town,	or Location	of Death		- 1	. County of Death	
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	h with	Funeral Director	5455 Whi	tfield Cl	hapel Road			20706					ted State	
98	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ		ried 2 Married	12. Was Decedent Armed Forces 1 Yes 2 4 If Yes, Give			Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X N	ban, Mexicar	n, Puerto Rica	Yes or No- n, etc.)		14. Race - Ameri Black, White, Specify: P1 a.	etc.
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P.O.	that the	, Ph	Part II. Other signi	ficant conditions	contributing to death	but not res	ulting in the t	underlying cause	given in Part	i.	23e. Did to	obacco	use contribute to t	he cause of death?
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ior	death	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not	be 28e Place of In	iury - At ho	me farm str	M 1 eet, factory, offic	Yes 2		Location (S	Street an	nd Number or Rura	il Route Number.
Division of Vital Records,	lor A after Direction by		4 Homicide	determined		tc. (Specify		oot, lastory, onlo			City or Tou			, riodic i talinasi,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 2 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1	Certifying Ph	ysician: To the best o	f my knowl examination	edge, death and/or inves	occured at the tir	ne, date and inion, death o	place, and du	e to the ca	use(s) a	nd manner as state, and due to the ca	ed. ause(s) and manner stated.
	thin 2 the F	Me	only one) 3	Certifying Nu	irse Practioner: To the	e best of my	knowledge,	death occurred at	the time, date	e and place, ar	nd due to th	e cause(s) and manner as s ate signed (Month,	tated.
	5.2 1 €.3		200. Signature and		2 pRu	e,	, MD			216.		200. 00	1/5/	7/1
	7		30. Name and addr	ess of person who	completed cause of	death (Item	23a) (Tvne I		000	-/0.)		, , /	
R	3		Dr. Tesho		ne 3001 Ho	spita	1 Driv		Floor	Chever	1y, M	lary.	land 207	85
	Sta		31. Date filed (Mont	h, Day, Year)	32. Regist	ar's Signat	uire							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 31 2010 Physician/ 9:05 P BUSSIE JOHN MILTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death DOCTOR'S HOSPITAL PRINCE GEORGE'S LANHAM Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 578-56-5462 Yrs WASHINGTON, DC Director 69 1941 Usual Residence of Decedent 28a-f shov r than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 TyrYes 2 No MD PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8913 CRANDALL ROAD 20706 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Giv Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. BLACK Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th FORK LIFT OPERATOR PRIVATE other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment.
Important: If item 27 is marked
any injury or other free. မ WILLIAM BUSSIE WILLIE MAE BING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>CATHERINE M.</u> BUSSIE/WIFE 8913 CRANDALL ROAD LANHAM, MARYLAND 20706 20a. Method of Disposition 20b. Place of Disposition (Name of competery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 1/5/2011 LANDOVER, MARYLAND 1. Signature of Funeral ervice Licenses 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1 Inter the disease, or complications there used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse : 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months? Other (specify) Month Day Year Pregnant at time of death the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page performed' Yes 2 No 1 Tes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending injury s after death. Accident 1 Yes 2 No Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29b. Signature and title of certifier 063431 01/05/11 law. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Goodhuck Rd., Carham, MD. 20706 MD. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ edrou 35 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Vursing 0 Himore Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Nov 24 9. Birthplace (State or Foreign 1 XM 2 F Months Min. 212-11-9731 ^{Year)}936 Country) Director 74 Yrs. Nov Iran Usual Residence of Decedent Show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a, State Director 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2X No Montgomery Germantown 10e. Street and Number 10g. Citizen of What Country? Funeral 13103 Millhaven Place, Apt. 20874 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after δ 1 Never Married 2 x Married Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the 1 and once. 5+ Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပ Rafael Bedroud Golnaz Bedroud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mahin Bedroud/Wife 13103 Millhaven Place, Apt. G, Germantown,MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Jan. 3, Gate of Heaven 4 Donation 5 Other (Specify) 2011 Silver Spring, MD Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 560 University Blvd. W., Silver Spri Spring, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ascular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and burial-tra Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No q Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?
1 Yes 2 No After this certificate To the Hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 XNo 1 Yes Other မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation М 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29c, License number 29d. Date signed (Month, Day, Year) D 47683 mara Mille 12/31/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAN mond Miller 2835 Smith Avenue Sunte 203 Bulhmore MD 31. Date filed (Month Registrar's Signature State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:29 AM JOEL IRWIN BABCHAK Dec 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death HOWARD lumbiA HOWARD County General Hospita If Unde 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F Months Days 064213944 Washington, DC 213-44-3813 66 Director Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Columbia 1 X Yes 2 No MD Howard 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? United States 8820 Shining Oceans Way #403 21045 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 Yes AND No If Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Information Technology IT Consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Babchak Ida Horvich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore MD 21231 Trudy Babchak - wife 1444 East Baltimore Street, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Columbia Mem Park 1 X Burial 2 Cremation 3 Removal from State 1/3/2011 Columbia, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01163 Danzansky-Goldberg II/O Rockville Pi Memorial ke Rockvi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequince of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last 2 Due to (or as a consequence of) attending physicial for use as the buri Physician/Medical Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Year been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐No 24a. Was an has autopsy performed? Yes 2 No certificate Division of Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 🗆 Yes 2 🔀 No 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 176120 2010 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon 10710 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Sarah Irene Carico 9:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Lutheran Village Healthcare Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) VA 1 □ M 2XXF Hours Month Pay Year 1940 Director 216-38-6925 70 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1XXYes 2 No MD Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 71 Pump House Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes XX No. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify. "natural", Specify: Completed XXWidowed 4 Divorced White d 2 should be filed within 72 hours a alth and Mental Hygiene.

127 is marked other than "natura" or traumatic event, the Medical E. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Line Worker Noxell Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be flik tment of Health and Mental rant: If item 27 is marked o 2 John Freeman Ossie Hodge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Hochhalter/daughter 840 Ridge Road, Westminster, MD 21157 Department of Hea Important: If item 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place 1XXBurial 2 Cremation 3 Removal from State injuny 4 ☐ Donation 5 ☐ Other (Specify) Ayres Chapel Cemetery 12/29/2010 White Hall, MD 22. Name and Address of Facility Pritts Funeral Home & Chapel Signature of Funeral Service Licenses 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Checan Obstructive Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): tor: After this certificate has been signed by the attending physician the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural (Month, Day, Year) 5 Pending injury work? 1 ☐ Yes 2 ☐ No М 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Manswild, MD 30. Name and address of person who completed cause of death (Item 23p) (Type Print) Westminster, MD 21157. DR. PANSURIYA Malwim 32 Registrar's Signatur 31. Date filed (Month, Day, Year) State **DEC 28** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 31. Theresa Margaret Cannetti 2010 7:15 p.M. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2X□ F Hours 08-04-1921 **Director** 89 New Jersey |060-14-0519 Usual Residence of Decedent show 10b. County 72 hours after death with the Maryland than "natural", or items 23a or 28a-f sho he Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Maryland St. Mary's Lexington Park 10e. Street and Number 10g. Citizen of What Country? Funeral 21711 Saratoga Street USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Public Library is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Raymond Tesoro Anna Scocca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is Joseph E. Cannetti Saratoga Street, Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Jan. 3, 201 Charlotte Hall, MD Edward N. E 22. Name and Address of FacilityBrinsfield Funeral Home, P.A. Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Severe Metabolic Onset and Death Fh sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Oh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) notension Cause (Disease or linjury that initiated events and Due t (or as a consequence of) resulting in death) Last Physician/Medical Shock. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 Ø No Pregnant at time of death Month Day 9 Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After this certificate I filled in by the funeral director, page performed' Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2. No Certificate: To 1 🗀 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1- Natural 5 Pending injury ☐ Accident☐ Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MID. 19060473 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospitel Leonardtown ND 20650 AKhlaghi Mehrdad St. Maryy 31. Date filed (Month, Day, Year) 0 3 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 28 2010 JOSEPH CHACONAS DECEMBER DECEMBER Medical 10:03 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1649 ADDISON ROAD SOUTH DISTRICT HEIGHTS PRINCE GEORGE'S 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 ⅓ M 2 ☐ F Days Min. Months Hours 213-66-2630 **Director** 58 MARYLAND 1952 Usual Residence of Decedent 28a-f shov 10a. State with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County Director 10c. City. Town or Location 10d. Inside City Limits MD PRINCE GEORGE S 1 √2 Yes 2 ☐ No DISTRICT HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1649 ADDISON ROAD SOUTH 20747 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force þ 1 Never Married 2 M Married 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: GREEK Completed 3 Widowed 4 Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2YRS TRUCK DRIVER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NICOLAS CHACONAS MARGARET MAE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELLE CHACONAS/WIFE 22ND STREET S.E. injury or other _WASHINGTON, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation RIVERDALE CREMATORY 1/4/2011 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MARYLAND J.B. JENKINS FUNERAL HOME, INC. Signature of Funeral Sa ice License any in 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ach line Interval Between Immediate Cause (Final Onset and Death Physician/ COLON CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate Examine Dian to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Ectopic pregnancy Pregnant at time of death Month Day ed by the a detached for Yes 2 No 9 Unknown Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? After this certificate Yes 2 No 1 Tes 2 🛣 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 🔀 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending Accident Suicide 2 No Investigation 1 Tes 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41978 January 4, 2011 30. Hame and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Nader Tavakoli MD. 12200 Annapolis Rd., Glenn Dale, MD 20769

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN O 62011

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

Daniel Vincent Cordelli, Jr.

		Contract to the contract to th	ate of Death	Reg. No.									
Physical Exam		1. Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death								
Cai Lxai		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	December 31, 2010 4c. County of Death									
		4919 Baffin Bay Lane	Rockville	Montgomery									
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	The second secon	1 Foreig	ın								
Directo	4	220-50-6905 1XM 2F 5	9 Yrs. Months Days Hours Min.	Feb 28,1951 co	untry) KS								
any		10a. State 10b. County 10c. City, Town of	or Location		10d. Inside City Limits								
		MD Montgomery Roc	kville		1 Yes 2 No								
Maryla 28a-f	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cour	ntry?								
th the 23a or			20853	USA									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nastural", or items 23a or 28a-f aho injury or other travmatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto 		can Indian, Black,								
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36 in 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Satellite Instal	•	unication								
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21215–0036 and be filed within 7 Mental Hygiene, marked other than e event, the Medica	Be			tal Lorraine In	graham								
hould hould is man	၉	19a. Informant's Name/Relationship (Type, Print → Daughter 19b.	. Mailing Address (Street and Number or R	ural Route Number, Gity or Town, State,	, Zip Code)								
MD 2 sho raith and 2 sho			6588 Drysdale Ten										
Baltimore, permit. Pages I ar Department of Hee Important: If ite			politan Crematory politan Crematory										
Itim it. Pa urtmen ortant		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee											
Depa Depa		Acures & Charles	22 Name and Address of Facility Francis J. Coll: 500 University B	ins Funeral Hom lvd. W., Silver	e Inc. Spring.M								
Physiciar		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.			Approximate Interval Between Onset and								
Axamine.		Immediate Cause (Final disease a. Hypertensive Atherosclerotic	Cardiovascular Disease		Death								
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):											
	Ē	if any, leading to immediate Due to (or as a consequence of):			1								
2	Examiner	cause, Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
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876 tificate ng phy			Fetal death 3 Ectopic pregnan	23d. Date of delivery cy Month D	ay Year								
Box 687 e death certifit the attending of the ast	Physician/	past 12 months? 4 Pregnant at time of death 5	Other (Specify)										
O. Be t the der by the a	P. S.	Part II. Other significant conditions contributing to death but not resulting it	in the underlying cause given in Part I	23e. Did tobacco use contribute to ti	he cause of death?								
res that the signed by	5	Chronic Alcoholism	are the underlying educe given are are.	1 Yes 2 No 3 Proba									
Division of Vital Records, tal or Attending Physician: The law requiring a star death. a) Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed				opsy findings available								
eco he law ite has	l m			autopsy prior to co performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	ompletion of cause of								
tal Rection: The certificate	BeC	25. Was case referred to medical	26.Place of Death (Check or		2 110								
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n of ding Ph. h. After t		27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Tir	me of Injury 28c. Injury at Work? 2 1 Yes 2 No	28d. Describe how injury occurred									
isior Attencer death	Cat	2 Accident Investigation 28e Place of Injury - At home farm		28f. Location (Street and Number or Run	al Route Number City								
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Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. The Faneral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as it		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death											
To the within To the complete	Medical	one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.											
	≥	29b. Signature and tiple of certifier	29c, License number O.C.M.E.	29d. Date signed (Moni	th, Day, Year)								
- ~		30. Name and address of person who completed cause of death (Item 23a)	U.C.IVI.E.	January 1, 2011									
		Laron Locke MD. Assistant Medical Examiner 900 V	N. Baltimore Street, Baltimore, M	D 21223									
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	100										
Regis	trar	JAN UZ CUII BARRAS D. AN	And the second s										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Of Waryland State Of Waryland State AMEND#23eperMD1/11/11, BMW, McCo RegistraMEND#23bperMD, 1/11/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2345 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death aure! MA Prunce Geo Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2X F 215-38-6610 Director Yrs Usual Residence of Decedent items 23a or 28a-f show her must be notified at should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🔀 Yes 2 🗌 No Montgamery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13910 Castle Blvd, 20904 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 9 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) event, the 12th Child Care Provider Child Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F Willie Simms Massie Williams other traumatic and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Freckleton/daughter 13910 Castle Blvd, #T-2, Silver Spring, MD 20904 Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Ardent Cremation Svc: 12/30/10 Hanover, MD Funeral Service Lic ase 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure/List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?
1 Yes 2 No Year Day 9 X Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 XUnknown peen Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Ser autopsy performed? Vascular Dementia After this certificate I 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 🗖 No Other: မ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D completed filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title D70093 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital OP 7300 Van Dusen Rd. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $12^{\text{M}}2^{\text{th}} / 2010^{\text{ay}}$ Frederick Cohen 553 PM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 6. Sex 1 M 2 F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 578-38-8963 80 Yrs. 10//27/74930 Washington, DC Director Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 □ No 10e. Street and Numbe 10f. Zip Code iral", or items 23a or Examiner must be r 10g. Citizen of What Country? Funeral 14800 Pennfield Circle #310 20906 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural" 3 Widowed 4 Divorced Completed WW II Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Owner Retail Carpet d 2 should be filed wii alth and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Herman Cohen Rose Bernstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Jeffrey Cohen - son 5802 Nicholson Lane #405 Rockville MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 X Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) King David Mem. Gardns 12/29/10 Falls Church, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 M01163 23a. Rant F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ teroscherote disease or condition resulting in death) -00000M Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any leading to inneclat cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial ransit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Renal Failvre Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{D} \) No CONCER 24a. Was an has autopsy performed? Yes 2 No certificate To the Hospital or Attending Physiciam: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, it 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending neral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signe d title o 29c. License number 29d. Date signed (Month, Day, Year) D54 10 2-6 10 6 Physician FMERMENCY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Conard 8600 Old Georgetown Road Bethesda MD 20814 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 <u>John Edward Cromwell, III</u> December 3:15 Medical A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery 12105 <u>Arbie Road</u> Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 1950 Maryland **Funeral** (Month, Day, 1 🛛 M 2 🗆 F Months Days Hours Min Director Yrs 215-48-6757 60 Aug. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Silver Spring 1 Tes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12105 Arbie Road 20904 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Caucasian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Environmental Consulting Consulting Firm Be 17. Father's Name (First, Middle, Last) John Edward Cromwell Jr. 18. Mother's Name (First, Middle, Maiden Surname) ည John E. Cromwell III Doris Pearce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca A. Gatwood, Spouse 12105 Arbie Road, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/30/10 Ft. Lincoln Crematory Brentwood, Maryland 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Simple Tribute M01294 INEX 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Etysician/ Opset and Death Years disease or condition Metastatic Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to (c) as a consequence on. and and al-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Year 4 Pregnant a Day 2 No ed by the a detached f 9 Unknown signed by details Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy page performed?

1 Yes 2 No death? 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗵 No ၉ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 Pending after death.

I Director: Af 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ertifier 29c. License number 29d. Date signed (Month, Day, Year) D0035045 12/22/2010 ried cause of death (Item 23a) (Type, Print) Philip G. Henjum, M.D. 30. Name and address of person who complete 18109 Prince Philip Dr. #200 Olney, MD 20832, Philip Henjum, M.D. 31. Date filed (Month, Day, Year)

State

Registrar

Registrar's Signature

29

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- State of Maryland / Department of Health and per dr/in, g911,01/25/ Registrar Amend Items 28a,b,c,9,10d per dr/in, g911,01/25/ Certificate of Death	Mental H	ygiene (3033					
Physicia	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day										
Medic Examir	cal	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	12	12 29 2010 1321							
Examin	ier	Civista Medical Center La Plota		4c. County of Death Charles							
Funeral Director		5. Social Security Number 6. Sex 1X M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of B (Month, D			ce (State or Foreign					
À		Usual Residence of Decedent	9 110	11752	TCAG						
iryland a-f show ied at	Funeral Director	10a. State 10b. County 10c. City, Town or Location			10d	. Inside City Limits 1 Yes 2 No					
the Ma or 28¢ e notif		10e. Street and Number Noodbridge 10f. Zip.dde		10g. Citizen of	What Country						
s 23a		5079 Cannon Bluff 22192	usa								
r death r item iner n		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)		ce - American						
036 s after ral", o Exam	ed by	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: Year or Dates.									
21215-0036 within 72 hours after giene. er than "natural", o , the Medical Exam	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ina	16b. Kind of Business Industry							
121 ithin 7 ene. than	Com	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired)				TOTEDO					
ING 21215-0036 Filed within 72 hours after death with the Maryland tall Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Be	5+ SENIOR SCIENTIST 17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle								
_ ~ ~ ~ ~	욘	SAM CARTER GRACE A	LLEY								
四 英語 5 四		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura									
		BEVERLY CARTER - WIFE 5071 CANNON BLUFF DRIV	/E, WOO	DBRIDGE 20c. Location							
0		1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State	-2011	WOODBRI	•						
Baltimore, permit, Page 1 and Department of Hea Important: If item any injury or othe		21. Signature of Funeral Service Licensee 22. Name and Address of Facility									
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			A	pproximate terval Between					
Physician/		Immediate Cause (Final disease or condition	çng			nset and Death					
Medical Examiner		resulting in death) Due to (or as a consequence of):									
	ner	Sequentially list conditions, if any, Vacing L. Immediate Due to (or as a consequence of)									
executed an and rial-transit	Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.									
o = := 1	dical E	resulting in death) Last Due to (or as a consequence of):									
icate b	ledic	d									
n certifica ending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Da	ate of delivery						
box e death the atter thed for u	Physician/Me	in the past 12 months? 1		Mo	Month Day Year						
that th	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use cont	ribute to the c	ause of death?					
quires quires en sig	ted k		10	Yes 2 🗆 No	3 🗆 Probab	ly 4 DUnknown					
vital meconds, vsician: The law requires s certificate has been significater, page 2 should I.	Completed		24a. Was	psy	prior to comp	findings available letion of cause of					
n: The ficate or, pag		25. Was case referred to medical 26. Place of Death (Charle	1 \(\text{Yes}		death? 1 🗌 Yes 2	No					
ysicia ysicia s certi	To Be	examiner? Hospital:	,	idence 6 🗆 Othe	or (Specify)						
ng Ph fter th		27 Manney of Doot		how injury occurre							
ttendi death.	Certificate:	2 🛮 Accident Investigation 3 🔾 Suicide 6 🖂 Could not be									
al or Attendin s after death. Il Director: Aff		4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	Street and Numbe wn, State)	er or Rural Ro	ute Number,					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	the time, date	and place, and due	e to the cause	(s) and manner stated.					
To the within.		only one) 3 Gertifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place 29b. Signature and title of certifier 29c. License number	e, and due to the	ne cause(s) and ma	anner as stated	d					
		1 mucas	4	12/3	1110						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7	1-17	110						
State	e	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	-1)	_	·						
Registra		1 JAN 25 2011 Janua B. Jaks									

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

Russell Alexander MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signature

29c, License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

December 24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh 912 2-3-11 vt State of Maryland Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year AM Nellie Dixon Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Crescent Cities Riverdale Prince Georges 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 St Director Yrs 579-24-3756 96 /26/191 Carolina Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No Riverdale MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20737 4409 East West Highway filed within 72 hours after death at Hygiene. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 Jerrit. Page 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 🎖 Widowed 4 □ Divorced Specify: Black Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)
Domestic Worker Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry 3Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wright Riddick Roseatta Riddick any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>Earnell Brown/ Daughter</u> Luzon AVe. NW Washington, DC 20012 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 12/21/10 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, cc0278 3831 Georgia Ave. NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ ANTERNOSCUENOTOS CANDIONAS C disease or condition resulting in death) ears Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy forι 5 Other (specify) Month Dav Year Pregnant at time of death g Unknown 9 Unknown by s been signed by should be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Toknown 24b. Were autopsy findings available prior to completion of cause of death? 949 Was an certificate has page 2 autopsy 25. Was case referred to edical examiner? performed 0 1 Yes 2 No Be in by the funeral director. 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 Tyes 4 Vursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: After t 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat to the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number P 29d. Date signed (Month, Day, Year, of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) 32: Registrar's Signature State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No. 1 4 3 0 3 6												
	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Plizabeth Fig. 2. Date of Death December Decembe										3. Time of Death 1027 AM M	
wa.	Medic Examir													
-,4	Funeral Director		313-22-2132	¬¬X_	(In yrs. las 37	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours		8. Date of Bir 2 ^{(*/1} 15,/ ^D 1		9. Birth New ^{Con}	place (State or Foreign
\mathfrak{N}	aryland ka-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County MD Montgom		-	Town or Loc		·-··						10d. Inside City Limits 1 Yes 2 □ No
1/CK	with the N 23a or 28 ust be not	Funeral Director	10e. Street and Number	0e. Street and Number 10f. Zip Code 10g. Citizen								izen of What Country?		
9200	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates.			11	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:					14. Race - American Indian, Black, White, etc. Specify: White		
yland 21215-(within 72 hou giene. e r than "nat the Medica	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker							g	16b. Kind of Business Industry Own Home			
	ild be filed v Mental Hyg larked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Joseph Birnman		,						(First, Middle, Shuck	Maiden	Surname)	-
, Mar	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship (Type Wayne Eig - son	oe, Print)		13 Ma	plewo	od E	ark (or Rural Court	Route Numbe	r, City o sda	r Town, State, Zip MD 2081	Code) +
limore	Page 1 a treet of H trant: If ite tant: If ite jury or ott		20a. Method of Disposition 1)	cer	ace of Dispos metery, crem ean Me	natory or ot	her place	s)	12/29	ate 9/10		ey, MD	own, State
Ball	permit Depart Impor any in		21. Signature of Funeral Service License	₩01	163	D ² å	Name and 170 k	ky-(ock\	8 Tab	erg N	lemoria Rockv	116	hapels II e MD 2081	3 <u>c</u>
C	Physician/ Medical Examiner	ıer	Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): b. Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):									Interval Between		
s, P.O. Box 68760	physician and the burial-facti	edical Examiner												
	law requires that the death certificate be executed as been signed by the attending physician and 2.2 should be detached for use as the burial-tents.	Completed by Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 conths? 1 Yes 2 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birt							23d. Date of deliv Month	23d. Date of delivery Month Day Year			
	uires that the des n signed by the a lld be detached f	d by P	Part II. Other significant conditions cor Dementia, Alzhei	o .		ting in the ui	nderlying c	ause give	en in Part I		_			he cause of death?
Recorc	sician: The law require certificate has been si lirector, page 2 should I	Somplet	Hypertension Hyperlipidema								24a. Was autor perfo 1 Yes	osv	prior to co	psy findings available impletion of cause of
Division of Vital Records,	ysician: is certifical	Be	25. Was case referred to medical examiner? 1 □ Yes 2 ▼ No	ospital:	. a 🗆 🗆	D/O-t	. a 🗆 Do	Other	ce of Deat		only one)			
	Attending Physician: The or death. ector: After this certificate P by the funeral director, page	Certificate: To	A TE impatient 2 Envotipation 3 Est Noting Home 5 Est Residence 6 Envoting Rome (Specify)											
Divi	io the Hospital or Attending Physio within 24 hours after days the for the Funeral Director. After this ce completed filled in by the funeral director.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place.								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Da)								use(s) and manner stated. cated.				
	10		Patria	D 10	lor	7m)	D	21392					cember 2	
			30. Name and address of person who co Patricia Kellog N	1D 1201 Se	ven/1	ocks		Rocl	kvill	e MD	20854			
\$4.	Stat	e	31. Date filed (Month, Day, Year)	12. Registrar	s Signatur	e par	Kall							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Cathleen Ebel December 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional Hospital Laurel Laure Prince 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 8 Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 📉 Hours 577-60-7081 (°1°)939 Director 7 1 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD P.G. Laurel 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 12804 Fernwood Turn 20708 USA items 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or any injury or other traumatic event, the Modification once. Black, White, etc Ь þ Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William F. Ebel Margaret Carney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 536 East Drive, Cindy Quaster/Niece Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Jan. 2011 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Silver Spring, 21. Signature of Funeral Service Licensee Name and Address of Facility ancis J. Collins Funeral Home O University Blvd. W., Silver 500 Spring, MI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Acute Respirator disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner oculated leura Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events oy the attending physician and Due to (or as a consequence of): Exami Failure Acute Renal Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Sepsis Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Day Pregnant at time of death Month Year ate has been signed by the apage 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hosping.

Within 24 hours after death.

To the Funeral Director. After this certificate has I autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) **Natural** injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2 D0012962 December 28, 2010

Registrar
DHMH 17 Rev 7/2009

State

Zoras

lda

7300 Van

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-lacer, MD

. Registrar's Signature

Laurel Regional Hospital

20707

Dusen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 25, 2010 Month 4:50 MPM December GENEVIEVE FLORENCE FEESER a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Taneytown 2232 Crouse Mill Road If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 1 M M July 27,1919 Maryland 213-16-9485 91 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Taneytown Maryland Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21787 Road 2232 Crouse Mill 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3√Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Laborer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pauline Null David E. Yealy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17340 Littlestown, PA 385 Lumber Street, Yvonne G. Davis/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2010 Taneytown, MD Grace UCC Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 136 E. Baltimore St MD 🔼 Myers-Durboraw Funeral Home 23a. Part1. Enter the disease, or complications that dauked the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 mos Cerebrouzzeuler Accident Due to (or as a consequence of): 7 20 w Hugertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2⊡No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

Director

Funeral

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Completed

Be

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death with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicone.

Maryland 21215-0036

Baltimore,

Box 68760.

Division or Vital Records, P.O.

The law requires that the death certificate be executed physician and s the burial-tran atte page 2 certificate

After

Hospital or Attending

Examiner Physician/Medical þ Completed Be ٩ Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

IF FEMALE 9 Unknown

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

1 🔲 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy perform 1 Yes 2 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

5 Pending investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

043643

29c. License number

Frederich St

29d. Date signed (Month, Day, Year)

TANECTOWN, MO 21787

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

76 4. TATE 4900 MUD

Barker

State Registrar

Medical

31. Date filed (Month, Day, Year) **DEC 27**

32. Registrar's Signature

E Fur Dire permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Baltimore, Maryland 21215-0036 Physic Med Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760

			se Type or Pr											
		For StateMEND#31, See#32 Registrar		Co AM	END#24a	intment of	Health and 11/10; BMW, I Death	MbCo	ygien Reg. N	e 2010	43039			
ysicia Medic		1. Decedent's Name (First, Middle, I		6				2. Date of D Month		Year	3. Time of Death			
amin		4a. Facility Name (If not institution, g		nital		4b. City, Town, o	or Location of Deatl	h		c. County of Deat				
neral ector				76 (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days								
ed at	tor	Usual Residence of Decedent 10a. State 10b. County			, Town or Loc						10d. Inside City Limits			
se notifie	I Director	MD Montgor 10e. Street and Number	nery	Broo	kville	10f. Zip Code			10g. C	1 Yes 2 No				
must	Funeral	19900 Zion Road	12. Was Decedent	Ever in U.S.	13 W	20833	Hispanic Origin? (Sp	necify Yes or No	USA		rican Indian			
Examiner	ρ	1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armod Farago	No	lf	Yes, specify Cub	an, Mexican, Puert		14. Race - American Indian, Black, White, etc. Specify: Black					
he Medica	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)	s Education grade completed) College (1-4 or	5+)	(Give k life. DC	NOT use retired,	during most of wor)		ľ	Kind of Business				
ic event, ti	To Be (10th 17. Father's Name (First, Middle, Las Roosevelt Frazie	,		Super	VISOR Sa	enitation 18. Mother's Nar Mable L	me (First, Middle		ty of Ro	OCKV111e			
r traumati		19a. Informant's Name/Relationship Sarah N. Frazier	(Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19900 Zion Road, Brookville, MD 20833									
any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐ Removal from State	ce	ace of Dispos	ition (Name of atory or other pla	1	Date	20c.	Location - City or				
any inju		21. Signature of Funeral Service Lice		ich	22.	Name and Addre	ess of Facility S	nowden	Fune	eral Home				
ian/		23a. Part 1. Enter the disease, or co shock, or heart failure. Ist onl Immediate Cause (Final disease or condition	om lications that cause y ne cause on each lin Respire	ie.	<u> </u>	0	ng, such as cardiac			سدنا	Approximate Interval Between Onset and Death			
dical iner		resulting in death)	Due to (or as	how	ence of):	hstrul								
transit	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	C. Due to (or as											
the burial-	ш	resulting in death) Last	d	a conseque	erice oi):									
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		livery Day Year										
ld be detac	d by Ph	Part II. Other significant conditions	λ		-		iven in Part 1.				the cause of death?			
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ector, p	a B	25. Was case referred to medical examiner?	Hospital:				lace of Death (Che	1 ☐ Yes ck only one)	2,4,11	vo <u>l</u> l ⊟ fes	3 2 <u>A</u> J 140			
neral dir	te: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 Inpati 28a. Date of inju (Month, Da	iry 2	R/Outpatient 28b. Time of injury	3 DOA Oth	y at	lome 5 Res 28d. Describe		6 Other (Spec	ify)			
n by the fu	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	tion t be	ury - At hon		M 1 🗆	Yes 2 No	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
ed filled i	Medical C	29a. Certifier 1 Certifying P	hysician: To the best of	my knowle	dge, death or	ocured at the time	e, date and place, a	and due to the c	ause(s) a	and manner as sta	ited. cause(s) and manner stated.			
comple		only one) 3 Certifying N 29b. Signature and title of certifier	urse Practioner: To the	best of my	knowledge, de	eath occurred at the 29c. Licens	e time, date and pla	ace, and due to t	he cause	(s) and manner as ate signed (Month	stated.			
		M. A. Tlavan	ur, ru	· n .		D00-	71314		1	29/201				
		30. Name and address of person wh					e. Olnev	MD 208						

State Registrar 31. Date filed (Month,

Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Genevieve Mary Gary Dec 2010 3:45 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Dove House Hospice Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 - F Months Hours Country) 059-20-7308 88 Director /17/192 New York Usual Residence of Decedent Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: Item Medical Examiner must be notified at 10c City Town or Location Director 10d. Inside City Limits MD Carroll Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1519 Bachman's Valley Road 21158 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify white 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Suchoski Julia Wilchevicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 Page 1 and 2 Michael P. Gary, Sr. 1519 Bachman's Valley Rd., Westminster, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 and Department of F 20c. Location - City or Town, State 1X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place, 12/30/2010 4 ☐ Donation 5 ☐ Other (Specify) Long Island National Farmingdale, NY Signature of Funeral Service Licensee 22. Name and Address of Facility M00741 Eline Funeral Home 934 S. Main St. Hampstead. Md. 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Drucy Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated every limiting the control of the Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 Wo Pregnant at time of death Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy ☐ Yes 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗂 No Other: ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence Certificate: 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 2035 Mo ollo WJL -010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 2(NU 31. Date filed (Month, Day, Year) State 32. Registrar's Signature OEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Month Physician/ Dec. 9:40 P M Joseph M. Galtieri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 8. Date of Birth (Month, Day, Year) Oct. 11, 1940 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. 1 DXM 2 D F Months Hours Director 70 Oct. 071-32-8630 Usual Residence of Decedent Show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State Director Ocean Pines MD Worcester 1 ☐ Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 USA Funeral 79 Seafarer Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Txyes 2 No Korea 1 Yes 2 X No Specify: white Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Air Condition Tech. Baltimore Air Core Maryland: Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Galtieri Lucille Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 79 Seafarer Ln. Ocean Pines, MD 21811 Grace M. Galtieri- wife ひっら ひらひ Baltimore, I 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State First State Crem. Dec. 29, 10 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign we of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stroke disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Xves 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No certificate Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) director examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Division 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zeeshon, Aut 9733 Health Way Drive Berlin MD 21811 DH 5+1 31. Date filed (Month, Day, Year)
DEC 2 9 32. Redistrar's Signature State

Registrar

Galtier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Sandra Elaine Guthrie December Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Birthplace (State or Foreign Country) 1 □ M 2 😾 F Months Days Hours Min. Director 579-66-6029 59 08/21/1951 Wash. D.CUsual Residence of Decedent f show ural", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Md. Prince George's 1 X Yes 2 No Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3322 Curtis Drive # T-1 20746 U.S.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: "natural", 3 - Widowed 4 - Divorced Year or Dates Specify: Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Accountant/Dept. of State years U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o Irvin Carter Mabel (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Guthrie/Son 6939 Greenvale Pkwy., Hyattsville, Maryland 20784 20a. Method of Disposition Page 1 & 20b. Place of Disposition (Name of Jan. 4,11 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) any injury or 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory.Inc Reltsville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final ani Approximate Interval Between Anteny Immediate Cause (Final Pisesse Onset and Death (ovenant Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Year 1 ☐ Yes 2 ☐ Unknown detached 9 Unknown ils certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate performe Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Certificate: 27. Manner of Death 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide 1 Tes 2 🗌 No after death Director; Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29d. Date signed (Month, Day, Year) 5232 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue, Takoma Park, Maryland James K. Lightfoot, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 8 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ 0205 AM 2010 Sheldon Abraham Goldberg Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. **Funeral** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🛣 M 2 🗆 F Days Hours New York Director 127-30-6390 Sept 1939 Usual Residence of Decedent shov 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Prince George's 1X Yes 2 ☐ No Greenbelt 10e, Street and Number ь 10f. Zip Code 10g. Citizen of What Country? must be by Funeral **23**a 7848 Jacobs Drive 20770 USA ral", or items? Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. 1 X Never Married 2 Married Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 - Widowed 4 - Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Military Historian US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hyman H. Goldberg Nellie Stiffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derek Thompson - Friend/POA 7116 Ora Glen Court, Greenbelt, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Mt. Lebanon Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/30/2010 Adelphi, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CARDIAC ARRHYTHM HA disease or condition FATAL Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown ed by tl signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy certificate 1 Tes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 1 Yes Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury n 24 hours after death.

• Funeral Director: After the functed filled in by the function. Accident 1 🗌 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D45490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL DRIVE CHEVELLY 20185 VIL GUPTA, MD MD 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

JAN 0 8 2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 439 December Kathleen Louise Galleher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Hours July 19, Year 940 70 578-52-9525 Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director ems 23a or 28a-f s r must be notified Burtonsville MD Montgomery 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20866 USA 14201 Ballinger Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter edical Examiner Armed Force: Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No by 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates er than "natur , the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Credit Manager is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edith Theresa McQuade Peter Joseph Ellis and 2 should by Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 18221 McKernon Way, Poolesville, MD 20837 Eileen M. Foy/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery 3 Dec 4 Donation 5 Other (Specify) 2010 Silver Spring, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd., W., Silver Spr 21. Signature of Funeral Service Licensee Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ardio pulmonar Medical resulting in death) Due to (or as a consequence of): Examiner Shoc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and neumonia Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) the & 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 Yes 2 No certificate 2 - No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) inature 0064413 and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD 20850 Smith MD 91901 Medical Ctr Br vanita 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ HUMPHREY SR. **EDWIN** JAMES 2010 Dec. 31 2019 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral Oct. 12, 1922 1 ☒ M 2 ☐ F Months Days Hours Min. MT 88 Director 384-14-8600 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medio I Examiner must be notified at Director 1 Yes 2 X No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 3505 S. Leisure World Blvd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 19 3 Widowed 4 Divorced Completed **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Northeastern Conf. 5+ Minister Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last, ည Willie Lee Barlow traumatic Virgil Walter Humphreys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Margaret Richardson-Daughter 2102 Arctic Fox Dr. Bowie, MD 20721 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State VETERANS CEMETERY 01/20/2011 Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Marshall-March Funeral Homeof Maryland
MD 20746 Signature of Fineral Service License 4308 Suitland Rd. Suitland, 23a, Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Acute Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami burial-transit Bilateral Pneumonia that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown ed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, or Attending Physician: The law requires Dehydration 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Acute Renal Failure autopsy page 2 Hyperkalemia 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 X No ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury work? 1 X Natural 5 Pending the Funeral Director: Aft 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D68096 ddress of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST Glean Rd Silver Spring MD 20910 32. Registrar's Signatu State JAN 1 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Russell Harry Humes December 2010 07:45 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartland Nursing Facility Hyattsville Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 226-24-3970 Director 88 July 3, 1922 Brightwood, Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at D.C. Washington 1★Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 612 Farragut P1. 20017 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2K Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Me Elementary/Secondary (0-12) College (1-4or 5+) 6th Special Police Southern Railway 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Humes Lizzie Thomkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ica Humes / Wife 612 Farragut Pl. N.E. Washington, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☑Removal from State Chestnut Grove Bapt. 4 ☐ Donation 5 ☐ Other (Specify) 1/8/2011 Brightwood, Va. 21. Signature of Funeral Service Licensee Name and Address of Facility Alexander S. Pope P.A. 5538 Mariboro Pike/Prorestville, Md. 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Tes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ို 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a e Funeral I

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 0 5 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWER PARKNAY GREGORBELT MARYLAND 2072

MO

7325A MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Deceme Truett Andrew Henricks Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Yea
Sept 16, **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F Year) 380-58-8673 Director 57 Yrs 1953Kirbyville. Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d Inside City Limits Maryland Prince Georges 1X Yes 2 □ No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12326 Woodwalk Terr. 20721 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Air Traffic Controller CSSI-FAA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Benjamin Henricks Elmora Bendy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2201 Bryn Mawr Ave. #1807 Philadelphia, Pa. Cecelia Henricks / Wife 19131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Riverdale Park 4 Donation 5 Other (Specify), 1/4/2011 Riverdale, Md. 21. Signature of Funeral Service Licen Allexanders of Sacility Pope, P.A. 5538 Mariboro Pike/ Forestville, Md. and 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between METASTATIC PROSTATE Immediate Cause (Final CANCER Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month signed by the at d be detached for Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate funeral director, pag 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 2 **N**No Other: 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 124 hours after death.

Per Funeral Director; Al bleted filled in by the fu Accident Investigation 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Abdella im D 1899200E mukemil

State Registrar 31. Date filed (Month, Day, Year) JAN 0 5 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUKEMIT ADDE (I PIMD 12200 Annapolis Rd., Suit 229, Gkin Dale, MD.)

DHMH 17 Rev 7/2009

Ramon Ulceda 10-09767 Pleas

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State of Maryland / Department of Health and Mental Hygiene	

State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death												90090			
Dhysisia	. m /	Registrar 1. Decedent's Name (First, Mid	ile.Last)			erunca	ile oi i	Dealli			2.	Date of Deat	eg. No. h		3. Time of Death
Physicia Modical Examin		Ramon		eda	Н	ernaı	ndez					Month December	Day Yea 18, 2010	r	0624 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, o Unit Block of N. Lakewood Avenue Baltimore											4c. County of	of Death	
Funeral		5. Social Security Number	6. Sex		7. Age (In y	rs. last birth	iday)	If Under 1 Year If Under 24Hi			Hrs.	8. Date of Bir	th (MM/DD/YYYY	9. Birl	hplace (State or
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		Usual Residence of Decedent		٠. ١			710.	L		<u> </u>					
wa v		10a. State 10b. County				City, Town o									10d. Inside City Limits
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215-0036 se filed within 7 that Hygiene, sked other than ent, the Medica	Be C	Claro Heri		z								Uced			
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 X Burial 2 Crematic	n 3 🔏 R	emoval fro	m State		ry or othe	r place)				Date	Espart	ca,	La Union,
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Physician		23a. Part I. Enter the disease, of failure. List only one caus			used the de	ath, Do not	enter the	mode of	dying, s	uch as cardi	ac or re	espiratory arro	est, shock, or hea	art	Approximate Interval Between Onset and
/ /Medical ≟xaminer		Immediate Cause (Final diseas	a. Gun	shot wo	ound to th										Death
1.2		or condition resulting in death)	Due to b.	o (or as a	consequenc	ce of):									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to	o (or as a	consequenc	e of):									
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Box 68760, e death certificate but the attending physical for use as the but	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months?		c. If yes, o	outcome of port	regnancy 2	Feta	il death	3	Ectopic pre	gnanc	у	23d. Date of Month		yay Year
ox 6 eath cer attendi	sicia	1 Yes 2 No 9 U	known a	= -	ant at time o	f death 5	Othe	er (Specia	fy)						
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rificate tor, page		25. Was case referred to medic	al					26	6.Place	of Death (Ch	eck on				
of Vital Recoing Physician: The law After this certificate has uneral director, page 2 si	o Be	examiner? 1 ✓ Yes 2 No	Hospita	al: 1 lr	npatient 2	ER/Ou	tpatient	3 🗌 DC	DA C	other Nu	ırsing l	Home 5	Residence 6	Other	: Scene
Division of Vital Records, ra for Attending Physician: The law requirers after death. 1 Director: After this certificate has been sited in by the funeral director, page 2 should to	Ţ.ii	27. Manner of Death 1 Natural 5 Death		8a. Date of Month.	of Injury Day Year) 2010	28b. T 0619	ime of Inj hrs			at Work?	S .	Bd. Describe I ubject sho	now injury occum t	ed	
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Divis al or / s after ed in b	Certification:	det	ild not be		of Injury - A Local St		m, street,	, ractory, o	опісе ви	ilaing, etc.		or Town, S	tate)		Baltimore, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		4 Homicide 29a. Certifier 1 CertifyIng I					th occurre	ed at the t	time, dat	e and place,			e(s) and manner		
To the within To the comple	Medical			ne basis o manner st		on and/or in	vestigatio	on, in my	opinion,	death occurr	ed at t	ne time, date	and place, and d	ue to the	e cause(s)
2	ž	29b. Signature and title of certif		(/	16 ·				License				29d. Date sign		
		alin	N	V	K	ui)			O.C.N	I.E.			December	18, 20	
		 Name and address of person Zabiullah Ali, M.D. 	Assistant				1 Penn	Street	. Baltir	nore, MD	2120)1			
-12	ate	31. Date filed (Month, Day, Year			gistrar's Sig				,			-	-		
Regist		JAN 04	2011	12	wa	B. 14	back								

DHMH 17 Rev 1/2001 OCME 2006

OCME

JUAN SANTOS HERNAdez

10-09865 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

AIII OIII		1- For State Registrar	Cel	rtificate of Dea	nth		g. No.				
Physicia Medical Examir	n/	Decedent's Name (First, Middle, Last) Juan Carlo:	Day Year 22, 2010	3. Time of Death 0035 hrs							
)	ŭ.	4a. Facility Name (if not institution, give stree		4b. City,	, Town, or Location of Dea		4c. County of Death				
		3721 Mount Pleasant Avenue 5. Social Security Number 6. Sex	7. Age (In yrs. la		imore der 1 Year If Under 24H	rs 8 Date of Rinth	(MM/DD/YYYY) 9. Birt	hplace (State or			
Funeral Director		none 1 ^M M 2									
Aaryland 28a-f show any 1 at once	ŗ	Usual Residence of Decedent 10a. State 10b. County Md		Town or Location	· · · · · ·			10d. Inside City Limits 1 X Yes 2 No			
death with the Maryland or items 23a or 28a-f sho must be notified at once,	D S	10e. Street and Number 331 East 28th S	treet	10f. Zi	ip Code 21218	10	g. Citizen of What Cour Hond	luras			
h-	by Funeral		Vas Decedent Ever in U. Armed Forces? Yes 2 X No Give Year es:		dent of Hispanic Origin? (cify Cuban, Mexican, Puer Hondur 2 No specify:	to Rican, etc.)	Specify:	nite			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itant: If teen 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed t	15. Decedent's Education (Specify only high Elementary/Secondary (0-12) 6	nest grade completed) ollege (1-4 or 5+)		al Occupation (Give kind o orking life. DO NOT use re		16b. Kind of Business/II Cleaning	-			
21215-0036 ould be filed within 7 Mental Hygiene. I marked other than it merked other than it event, the Medical	Be Co	17. Father's Name (First, Middle, Last) Saturnino Santo:	s Amaya			ne (First, Middle, Manager) ndra Her	nandez Ro	driguez			
MD 212. d 2 should be lth and Menta n 27 is marke	٥	19a. Informant's Name/Relationship (Type, Print) Brother / 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Elmer Alexis Santos Hernandez 331 East 28th Street Baltimore									
Baltimore, MD 2 semit. Pages 1 and 2 shou Department of Health and 1 important: If item 27 is rujury or other traumatic		20a. Method of Disposition 1 X Burial 2 Cremation 3 X Rei 4 Donation 5 Other Specify:	moval from State	crematory or other place			20c. Location - City or Siguater Comayagt	Town, State Deque, Da, Hondura			
Baltimo permit. Page Department o Important:		21. Signature of Funeral Service Licenses		9241	P ^{Addess} KTNALD Columbia E	lvd.Sil	ver Sprin				
Physician /Medical -xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wound of Head									
2.02.111.11.02		or condition resulting in death) Due to Sequentially list conditions, b.	(or as a consequence of	f):				·			
Ah =	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
e executed sian and sial - transit	Medical E	d. UNPENDED AME	NDED	-							
	Physician/Me										
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e faw require te has been si	Completed					24a. Was ar autops perform 1 ✓ Yes 2	y prior to co ned? death?	opsy findings available ompletion of cause of			
Vital Rec	ည် ရှိ	25. Was case referred to medical examiner?			26.Place of Death (Chec	k only one)					
f Vit	의	1 Yes 2 No	a Date of Injury	ER/Outpatient 3 1	DOA Other Nurs		esidence 6 🗸 Other:	Scene			
ion of trending Ph leath. ttor: After t	ation	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) Dec 22, 2010	0028 hrs	1 Yes 2 ✔ No	Subject shot	. ,				
Division At ours after derail Direct filled in by	Certification:	3 Suicide 6 Could not be 28	Be. Place of Injury - At hospecify) Local Stree		y, office building, etc.	or Town, Sta	reet and Number or Rur ate) easant Avenue , Balti				
To the Hospital within 24 hours To the Funceral completely filled	Medical	nd due to the cause at the time, date ar	(s) and manner as state nd place, and due to the	d. e cause(s)							
To with	ğΪ	29b. Signature and title of certifier	anner stated.	29	O.C.M.E.		29d. Date signed (Mon				
Sta	ta l	Donna M. Vincenti, MD Assis	tant Medical Exam	VASA	Street, Baltimore, I	VID 21201					
Sla Registr	~	VANI (14. 2011	1).	1362 500 1 -							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - StateAMEND#19b+20bperFH, 1/4/11, EMW, McCo Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elizabeth Jane Hartman Medical 201 6.15 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death National Luthern Home Rockville MD
If Under 1 Year | If Under 24 Hrs Montgomery **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 🗆 M 2 🖵 F Days Hours Min Country) Director 576-34-6599 7-23-1920 show ral", or items 23a or 28a-f shor 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d, Inside City Limits MD Montgomery Rockville 1X Yes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9701 Veirs Dr. 20850 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forc Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) School cafeteria manager Educatrion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Wilbur Clayton Adella Mae Hyman 19a. Informant's Name/Relationship (Type, Print) 2901^M Tieristire (vertal division of Filments); "Silve Giv SJovin State My 20906 Caroline Kremer/daughter 9701 Voirs Dr., Rockville, MD 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State G. West of the complete of the colored to the color 1 Burial 2 Cremation 3 Removal from State injury or 4 ☑ Donation 5 ☐ Other (Specify) 12-27-2010 Washington, DC . Signature of Funeral Service Licenses 22. Name and Address of Facility \$ Columbia Mortuary Service PA Level /M00969 9013 Annapolis Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition resulting in death) Medical or as a consequence of) Due to Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Pregnant at time of death Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ 4No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autons eral Director; After this certificate I filled in by the funeral director, pagr death? Yes 2 No 1 Tes 2 No B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 410 မြ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Priving Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State 24 hours Medical within 24 hound to the second the second to 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 005061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville Maryland Veirs Drive 11 En 201 mn

State

31. Date filed (Month, Day, Year)

JAN 04 201

\$2. Registrar's Signeture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 31, 2010 8:25 PM Harrison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery The Hebrew Home of Greater Washington Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🔏 F Hours 1 1^MOG PY 909 Baltimore, MD 215-09-4963 101 Director Usual Residence of Decedent of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Chesapeak Beach MD Calvert 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 3648 Brooke Side Drive 20732 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Goodwill Industries Book Keeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) :. Page 1 and 2 should be filk trrent of Health and Mental tant: If item 27 is marked ∢ Mollie Shapiro Lewis Rosenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 147 Bridle Drive, Angier NC 27501 Ronald Harrison - son 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 1/3/2011 King David Mem Gardns Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Danzanskyczsof Jackiv Danzanskyczof Idberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 M01163 23a. Part 1. Inter the rease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown or hart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Demetia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): igned by the attending physician and be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been signmpleted filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at ✓ Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Doo 64871 1-1-2011 Aug l 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20852 6105 Rockville MD Montrase Fazli MD 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 04 Registrar

122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 3. Time of Death Lillian S. Jones Physician/ 2010 11:55 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles County Nursing Home Laplata Charles Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min 7^{(Month}4^{Day}1906 Director 261 22 4300 FTorida 104 Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD P.G. Clinton 1. X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3201 Accolade Drive 20735 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 K No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th House Wife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Antoine Santhus Ida McPherson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjanette C. Feagan/Niece 201 <u>Accolade Dr.</u> <u>Clinton</u> MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🔯 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 12-29-2010 Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John T. Rhines Funeral Home LLC. B005 12th Street N.E. Washington DC 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions cause. (Disease or linjury Due to (or as a Exami burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig ; page 2 should b Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy hin 24 hours after death.

the Funeral Director: After this certificate performed death? Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b, Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? Accident Investigation 2 🗌 No filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Complying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 12/30/10 0005 am (Item 23a) (Type, Print) Terrace Drivestelo3 11637 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#7perFH, 1/4/11, EMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jones, Sr. Sande R. December 30,2010 6:40a Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital 9. Birthplace (State or Foreign If Under Hours If Under 1 Year 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** Month Day, Year 1930 Days Min. New York 1 X M 2 🗆 F May Director 075-22-0285 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Examiner must be notified at Director 1x Yes 2 ☐ No N/A DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 23a Funeral United States 20011 224 Quackenbos Street, N.W. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc by 1 Never Married 2 Married 9 African 72 hours after 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 "natural", 3 Widowed 4 Divorced American Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Director of EEO Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Bertha Miller Randolph Jones and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 224 Quackenbos Street, N.W. Wash., D.C. 20011 Page 1 and 2 sl ment of Health a ant: If item 27 is Susan Jones Johnson/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name or Date Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 D Other (Specify) Woodside, New York 01/07/2011 Calvary Cemetery 21. Signature of Funeral Service Dicense 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Wash., D.C. 20012 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Aspiration Pneumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) and -transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Yes 2 No signed by the a 1 ☐ res ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypernatremia, Dehydration, Urinary Tract Infection, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown law requires cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Chronic Obstructive Pulmonary Disease, Coronary autopsy death? Hospital or Attending Physician: The 124 hours after death. Funeral Director: After this certificate h 2 **X** No 1 Yes 2X No Yes <u>Artery Disease</u> completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA ျ 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury Certificate: (Month, Day, Year) 1 XNatural 5 Pending 1 Yes 2 No M Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 2 the 2

(Check

29b. Signature and title of certifier

Satuam Shah, 1500 Forest Glen Road Silver Spring, MD 20910-1484 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

NID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

D68096

29d. Date signed (Month, Day, Year)

December 30, 2010

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Marie Lunie Josselyn Dec.21 0530 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Takoma Park Montgomery Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 579-29-2079 44 Months Days Hours Min. 199277966 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits Examiner must be notified at Director Md Montgomery 28a-f Takoma Park 1 ☐ Yes 2X No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 811 Houston Avenue Apt.1 20912 USA death v 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 0 ģ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black "natural" Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Driver Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) School bus other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Andre Brizard Camila Brizard 19a. Informant's Name/Relationship (Type, Print) Yves Josselyn/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Houston Avenue #1 Takoma Park, Md20912 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Negroval from State 12/31/2010 Silver Spring, Md 5 Other (Specify) 21. Signature of Funeral Service Lice PHTTPADERINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween holism Immediate Cause (Final Physician/ mona disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner enous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) fransit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-t Physician/Medical that the death certificate be Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) been signed by the a should be detached t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has page 2 s autopsy this certificate To the Hospital or Attending Physician: the Funeral Director: After this certific upleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗌 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending 1 Yes 2 No hours after death. 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined within 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 21 2010 2 2326 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James K.Lightfoot 7600 MD Carroll Ave Takoma Park, Md 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael Jones December 10:21 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours Sierria Leone **Director** 578-72-6723 66 0177271944 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 908 Heron Drive 20901 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: 3 Divorced Completed ^{Specify:}African-American 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Accountant University Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Micah Jones Nanette Sudie Easom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ibiduni Jones-Spouse 908 Heron Drive, Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 X Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 01/10/2011 | Brentwood, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. Neva m MOIGAI 11800 New Hampshire Ave., Silver Spring, MD 20904 ado 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death Meumatosis intestinalis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

124 hours after death.

9 Funeral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the buriar transit attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tasuitis, respiratory 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗹 No 1 🗌 Yes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature Resident December 15, 2010 1205095106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Milan Vora, 675 President St. Unit 1804, Baltimere, MD 21202

State

Registrar

31. Date filed (Month, Day, Year)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 22, December Edward Jimenez 2010 12:15 p ^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital Center Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth Funeral Months Days Hours 1 X M 2 🗆 F Min (Month, Day, Yea, Director 19,1930 Puerto Rico <u>581–16–6168</u> 80 December Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🗶 No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3224 Beret Lane Avenue 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 X Yes 2 □ No Specify: Puerto Rican Specify: Hispanic 3 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Building Management** Maintenance Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Longinio Jumenez Damiana Delgado 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 Leonor Jimenez - Spouse permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other tra 3224 Beret Lane Avenue, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Parklawn Memorial Park 12/28/2010 Rockville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Cremation 21. Signature of Funeral Service Licensee Center 1040 Rockville Pike, Rockville, Maryland 20852 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) transit the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death, Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 38 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Day Year Pregnant at time of death ed by the 9 Unknown signed by t Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work thin 24 hours after death, the Funeral Director: Al mpleted filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier . License number 00050410 Name and address of person who completed cause of death (Item 23a) (Type, Print) Torner 31. Date filed (Month, Day, Registrar's Sign State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 23, 2010 11:45 PM Roger A. Knight Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Summerville at Westminster Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Min. Hours Septh. Daz 6 a 1912 Maryland 214-03-3661 98 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ¥ Yes 2 □ No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be I by Funeral 21157 USA 45 Washington Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Ь 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White Completed 3 XWidowed 4 Divorced "natural" traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Painting House Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental marked ೨ Charles Knight Martha Kerkhoff 19a. Informant's Name/Relationship (Type, Print)
Douglas W. Knight/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 103 Winterberry Lane, Westminster, MD 21157 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Sperfoombment Evergreen Mem. Gardens 12/28/2010 Finksburg, Maryland Signature of Funeral Service Licenses 2Printes A Francis Home and Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Rumon Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and s the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 attending IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Month Day Year g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed? Yes 2 AN death? this certificate [1 🗌 Yes or Attending Physician: 25. Was case referred to medical examiner? Be **Division of Vital** 26. Place of Death (Check only one) 1 ☐ Yes 2 📉 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ,Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No M Accident Investigation in by the 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie DIACIP 88 POOR Rd, Westministe 31. Date filed (Month, Day, Year) State Registrar OEC 2

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra/AMFND#5perFH.1/11/11;BMW,MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month P M Karben 2010 8:00 <u>Blossom</u> December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N Leisure World Blvd Spring Montgomery Silver . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) 1 - M 2 X F Months Days Hours 89^{Yrs.} **Director** 10/28/192 ŃΥ Usual Residence of Decedent show 10a. State 10b. County with the Maryland notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? ō 10f. Zip Code ge 1 and 2 should be filed within 72 hours after death with thit of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be Funeral <u>3310 N_Leisure World Blvd</u> 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 X No Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 - Widowed 4 - Divorced White 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elsie Titleman <u>Abraham Forman</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3310 N Leisure World Blvd. Silver Spring, MD 20906 Philip Karben / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2010 New Montefiore Cem. Babylon, New York 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc <u>Blake</u> 1091 Rockville Pike Rockville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ <u>Renal</u> Failure disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Metastatic Ovarian Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Unuerlying Cause (Disease or iinjury that in literal aventure) Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and attending physician and I for use as the burial-tr Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Year Day Pregnant at time of death 5 Other (specify) signed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2X within 24 hours after death.

To the Funeral Director: After this certificate has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 1 Tes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 🗌 Pending X Natural injury work?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar AMEND#8perFH, 1/4/11, BWW, McCo 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ [□]18,2010 1:35 P. M Kahn Doris December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4986 Sentinel Drive #101 Montgomery Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) 1930 **Funeral** April Day Months Days Hours Min. 1 D M 2 🔀 F ,2010 Pennsylvania 80 **Director** 164-24-9006 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County death with the Maryland other traumatic event, the Me ical Examiner must be notified at Director Bethesda MD Montgomery 28a-f 1 X Yes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code 0 10e. Street and Number United States Funeral items 23a 4986 Sentinel Drive #101 20816 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates. 0 þ 1 Never Married 2 Married 72 hours after Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Detail: Page 1 and 2 should be filed within 72 hours aft Separtment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any hiury or other traumatic event, the Merical Exa any injury or other traumatic event, the Merical Exa 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Supervisor 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Amy Ruhnquist Irwin Olson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi 4986 Sentinel Drive #101, Bethesda, MD 20816 Robert Kahn/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Georgetown University 2010
Medical Contents

Med 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 Donation 5 Other (Specify) Medićal Center 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Licenses /M00969 9013 Annapolis Road, Lanham, MD 20706 1=tru 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final Physician/ disease or condition resulting in death) Cance Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami anding physician and use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No for Month Dav Year Pregnant at time of death 9 Unknown the 9 Unknown been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hospital or Attending Physician: The law requires 1 1 ☐ Yes 2 ← No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? his certificate h I director, page 1 Yes 2 No 1 Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Hospital: 2 X No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury **Natural** 5 Pending 1 🗌 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medica Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 D 2251 December 23, 2010 W O 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8245 #211 wijconsilar. 3. Wills 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 04Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Certifica	ate of L	Death			Reg. No	5 .			
Physici		1. Decedent's Name (First, Midd	dle,Last)						2. Date of I	eath Day	Yea		3. Time of Death	
Medical Exami	iner	Mark Edwin	Lindler						Decem	ber 30,	2010		1502 hrs	
		4a, Facility Name (if not instituti		number)		i i		r Location of De	eath	- 1	4c. County o			
	ľ	22343 White Oak Ro					Leonardtov				St. Mary			
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birt	hday)	Months Day		Hrs. 8. Date of Min,	Birth (MA	//DD/YYYY	Foreign	nplace (State or	
Director		220-56-8218	1 X M 2 F		60	Yrs.	Widilais Bay	73 Hours		6/19	50	Cou	ntry) Maryland	
_		Usual Residence of Decedent												
* any		10a. State 10b. County		10c.	City, Town	or Location	1						10d. Inside City Limits	
and show	ō	Maryland St. Ma	ary's	Le	onard	town							1 Yes 2 No	
te Maryland or 28a-f show fied at once.	Director	10e. Street and Number					10f. Zip Code			10g. Ci	itizen of Wh	at Count	try?	
the la or	ᅙ	22343 White O	ak Road				20650			Uni	ted St	tate	S	
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -/ White, 6												an Indian, Black,		
death or ite	Funeral	1 Never Married 2 X M	1 Yes	2 X	No		_		Sito Modif, etc.)			,		
after	Ď		vorced If Yes, Give Your Dates:				es 2 X No			Specify: White				
hours	P	15. Decedent's Education (Spe						ition (Give kind e. DO NOT use		16b.	Kind of Bus	siness/In	dustry	
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5-0036 iled within 7 Hygiene. I other than	mo	17. Father's Name (First, Middle	6		<u>E1</u>	ectri	cal En		ame (First, Middl	M.	arine	Ele	ctronics	
11215-0036 Id be filed within 72 hours after death with the Maryland dental Hygiene. narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.											i Surriame)			
2121 buld be fill Mental I marked	To Be	Jack Griffith 19a. Informant's Name/Relations			195	. Mailing A	ddress (Strei		11en Boo		16 mber, City or Town, State, Zip Code)			
MD d 2 shoulth and d 2 is numatic	-	Leslie Lindle			41	•	,		d, Leona		,	,	20650	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-fah. Ir other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition	LYMITE		20b. Place o	f Disposition	n (Name of ce		Date		Location -			
Ore ges 1 t of H other		1 Burial 2 X Cremation	n 3 Removal	from State		ory or other								
Baltimore, permit. Pages 1 ar Department of Hes Important: If iter		4 Donation 5 Other S	pecify:		Brins				1/05/20	11 C	narlot	te	Hall, MD	
Baltimore, MD 2121; permit. Pages 1 and 2 should be fil popartment of Health and Montal I Important: If item 27 is marked injury or other traumatic event,		21. Signature of Funeral Serves Ricens 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22. Name and Address of Facility												
Physician	-	Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart A												
Medical		failure. List only one cause	e on each line.						,		,		Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Head Inju			Chronic	Alconol Us	e				_	Dodui	
			b.	a conseque	100 017.									
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760, cate be ex physician he burial	/Medical	IF FEMALE:		, outcome of					_	1 2	2d Data of	dalisans		
		23b. Was decedent pregnant in t			pregnancy 2	Fetal	death 3	Ectopic pre	gnancy	2.	3d. Date of o Month	Da	ay Year	
Box 68760, death certificate be the attending physic of for use as the burn of the burn	흥	past 12 months?	4 Preg	nant at time	of death 5	=	(Specify)			- 1				
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that the d	D P	Part II. Other significant condit	tions contributing	to death but	not resulting	in the und	erlying cause (given in Part I.					ne cause of death?	
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ion of Vital Records, P.O. Box 68 tending Physician: The law requires that the death certificath. for: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use as	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	2 ER/Ou	tpatient 3	DOA	Other Nu	rsing Home 5	Resid	ence 6	Other:	Scene	
n of V ding Phy.	2	27. Manner of Death	28a, Date	e of Injury	28b. T	ime of Inju	ry 28c, Inju	ry at Work?	28d. Describ		jury occurre	d		
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Divis Hospital or At 24 hours after d Funeral Direct tely filled in by	Certification:		Contract A Contract	Single	Family H	ome			or Town 22343 Whit	, State) e Oak F	Road, Leor	nardtow	n, MD	
8 4 E 5		29a. Certifier 1 Certifying P	hysician: To the be	st of my kno	wledge, dea	th occurred	at the time, da	ate and place, a	and due to the ca	ause(s) a	nd manner :	as stated	i.	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D										cause(s)				
29b. Signature and title of certifier 29c. License number 29d. Date signature									Date signe	d (Mont	h, Day, Year)			
		Va	N. 11				O.C.	M.E.		De	cember 3	31, 201	10	
Dena	ŀ	30. Name and address of person												
<i>y</i> '		Jack Titus MD. Der	outy Chief Medi	cal Exam	iner 90	0 W. Ba	timore Stre	et, Baltimo	re, MD 2122	3				
		31. Date filed (Month, Day, Yoar	2011 32.	egistrar's Sig	gnature	bare	1.1							
Regist	rar	JAN	LUII	noun	P.	gar								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** \mathbf{P}^{M} Jeffrey Michael Livingston 12/31/2010 6:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cherry Lane Nursing Center Prince George's Laurel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Min. Months Hours 1**X** M 2□ F 214-70-4873 54 Director 1/21/1956 Washington, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show notified at 1 ▼ Yes 2 No Director MD Prince George's Berwyn Heights 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or e ral", or Items 23a (Examiner must b 7613 Charlton Avenue 20740 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. hours after e filed within 72 hours after al Hygiene. other than "natural", or Its vent, the Medical Examine 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify. White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Payroll Clerk Ogden Foods n and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be i Lionel Claude Livingston Jacqueline Walsh Department of Health and Important: If item 27 is may any injury or a series of the se 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Livingston / Mother 7613 Charlton Avenue, Berwyn Heights, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 1/7/2011 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4739 Baltimore Avenue Boyl Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Rogers 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final unt mores by topica **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed Due to (or as a consequence of P.O. Box 68760. attending physician Physician/Medical the as ase 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy perform 2K No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director; After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 2

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 0-8 2011

29b. Signature and title of certifie

(Check only

as kunas

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Olubayo Oludara

Groven best,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ DECEMPER 31. 1242 PM Clarence Madison Lindsey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Doctors Community Hospital Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 18, 1**X** M 2 □ F Months Days Hours Min. Year) 1933 Caroline Cty. Va. Director 228-42-7901 Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Anne Arundel Hanover Maryland 1 Kyes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 1557 Rutland Way 21076 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc þ 1 Never Married 2 Married 2 🗌 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Potomac Bapt. Church 12 Minister Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charlie Madison Beverly Lucy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1557 Rutland Way Hanover, Md. 21076 Michael Lindsey / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/8/2011 Resurrection Clinton, Md. Donation 5 - Other (Specify) 21. Signature of Funeral Service Licens Vame and Address of Facility Pope , P.A. 5538 Mariboro Pikė/Forestville, Md. 20747 Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory aresi Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown the 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ျပ 1 Yes 2 🗆 No 1 Dispatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) n 24 hours after death.

• Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

P.O. Box 68760 Records, **Division of Vital** Hospital To the Hosp within 24 hor To the Fune completed fi

UNDSEY, ULARENC Baltimore, Maryland 21215-0036

State

Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 0 5 2011

me and address of person vito completed cause of death (Item 23a) (Type, Print)
2. Samuel H3 Fow 8118 Good La

certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Luck Road, Lanham

MDD60611

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:02 AM Lewis December Rosa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Regional HUSPITAL George's Laure If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 TXF Months (Month, Day, Year 04-05-192 248-74-4052 88 **Director** South Carolina Usual Residence of Decedent items 23a or 28a-f show ier must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Beltsville PG MD 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 Funeral 11340 Broken Bow Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or item ledical Examiner n 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 XWidowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene sant: If item 27 is marked other than 'ury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Domestic 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Williams ည Ella Hampton Joseph 19b. Mailing Address (Street and Number or Rural Boute Number City or Town, State Zio Code)
11340 Broken Bow Ct. Beltsville, MD 20705 19a. Informant's Name/Relationship (Type, Print) Rosa Cooper/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 01-8-2011 Brentwood, MD Department of Important: If any injury or once. 22. Name and Address of Facility Ronald Taylor II FH fure Funeral Service Lice 10583 Middleport Ln. White Plains, MD 20695 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ Respiratory tailure (Hypoxemic disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stage 3 sacral decubitus ulcer, Type 2 Diabetes Mellitus, should be 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Failure to thrive, Hypertension, A-fib, Vascular dementia, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy Pseudomonas Septicemia, CI 1 Yes 2 No this certificate 25. Was case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 1 XInpatient 2 ER/Outpatient 3 DOA မြ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 5 Pending injury work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I 29b. Signature and title of certifie and D60936 January 3, 2011 7300 Van Dusen Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdul M. Tak, Laurel Regional Hospital MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Year Edilberto Lopez Santelis 0621 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner) wiversity Main 04 Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 577–29–9594 6. Sex Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 10/23/ 1 XM 2 - F 1955 Mexico Director 55 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 🗆 Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Dearborn Avenue 20901 Mexico Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Maryland 21215-0036 1 □XYes 2 □ No SpecifyMexican White Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) J Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction should be filed with hand Mental Hygien 7 is marked other the Laborer 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ೭ Santelis Loreto Juan Lopez permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dearborn Avenue Silver Spring, Md20901 Teodra Lopez/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cemetery crematory or other place) Otumba, Estado De Mexico, Mexico 1 🛮 Burial 2 🗆 Cremation 3 🗗 Removal from State Ronation 5 Other (S Teodoro 1/10/2011 of Funeral Service Signat PHTLTPddcs. RIWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death ardio pulmonary arrest Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Months Examiner ARDIOMYOPATHI Schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar s the burial-t resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End-Stao renal Disease 3 Probably 4 Unknown 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? Yes 2 No has certificate 2 No 1 L Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: မ 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hin 24 hours after death.

the Funeral Director: After thi

mpleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 only one) 29b. Signature and title ertifie 29c. License number 29d. Date signed (Month. Day, Year) FM1222316 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Baltomore MD Greene Mallemat 31. Date filed (Month, Day, Year) Registrar's Signat State 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 29, 2010 8:35 AM Carl Christy Lipp Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Rockville Casey House 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min 1 X M 2 D F Months Hours Washington, DC 90 Feb. **Director** 6, 577-12-8486 Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland 10a, State Director Gaithersburg 1 🗌 Yes 2 🕱 No Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö pe i ns 23a r c must h Funeral United States 20877 403 Russell Avenue #813 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian Examiner Armed Forces?

1 Yes 2 X No Black, White, etc ō þ 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Plumbing & Heating Master Plumber Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic even once. မ Evelyn Adah Reeves Carl Christy Lipp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 403 Russell Avenue #813, Gaithersburg, MD 20877 Shirley Lipp, spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗌 Burial 2 🗶 Cremation 3 🗌 Removal from State 1/4/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) Lincoln Crematory Simple Tribute Funeral & Cresat Center Pike, Rockville, Maryland 20852 Tribute Funeral & Cremation 22. Name and Address of Facility 21. Signature of Funeral Service Licensee KOWE 1040 Rockville Pike, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myelodysplastic Syndrome years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and I-tr msit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death g Unknown 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🗶 No 24a. Was an autopsy performed? Yes 2 No has page certificate | Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **Hospice** 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending safter death.

I Director: Affine by the fur 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar (Check

only one

31. Date filed (Month, D

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number D37142

29d. Date signed (Month, Day, Year)

12-29-10

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 29 Day Dec. Physician/ 2010^{ar} 9:00 рм McCallen Dorothy J. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Shores Nursing Center Lexington Park St. Mary's If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 03-18-1928 1 □ M 2 🕅 F Months Days Hours Min. Pennsylvania 87 82 Director 198-20-9232 Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location aţ 10a. State within 72 hours after death with the Maryland Director Examiner must be notified 1 ☐ Yes 2 😾 No Lexington Park St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Number 23a Funeral USA 20653 45831 Sunburst Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 0 ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: "natural" 3 Widowed 4X Divorced White Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. d 2 should be filed within salth and Mental Hygiene.
n 27 is marked other thar er traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Public Schools Be 17. Father's Name (First, Middle, McCallen 18. Mother's Name (First, Middle, Maiden Surname) ပ McCullon Ruth Allison David Α. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau John P. McCallen MD 20619 California. Box 2171. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State 01-02-2011 |Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Jr. M0005222955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 perform 1 Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) director. Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PLNo Hospital: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 24 hours after death. Funeral Director: After 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the F only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Box 1890, LaPlata, MD 20747 Amir N. Alikhani, M.D. 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Leonard Bartholomew Mattingly 2010 11:10 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Callaway Hospice House 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex **Funeral** 1 ₺ M 2 🗆 F Months Hours October 23, Country) Maryland 215-64-6034 60 Yrs **1**950 **Director** Usual Residence of Decedent 28a-f show 10b. County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No St. Mary's Charlotte Hall <u>Maryland</u> 10f. Zip Code 10g. Citizen of What Country? Funeral 20622 38988 Chaptico Road USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or it Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 27 is marked other than "natural", traumatic event, the Medical Exar White Specify: Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done duning most of working life. DO NOT use retired) (Specify only highest grade completed) rould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture 12 Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Schercliffe Bartholomew Mattingly Agnes Cecelia Copsey nand N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Mary Beth Browne / Daughter 18670 Windswept Lane, Valley Lee, MD 20692 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or oth 1 X Burial 2 Cremation 3 Removal from State January 4, 4 ☐ Donation 5 ☐ Other (Specify) Helen, Maryland Oueen of Peace Cemetery 2011 22. Name and Address of Facility ture of Funeral Service Licens Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition JOUAMOUS CKLL MENTH CARCINOMA RIGHT resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed l by Division of Vital Records, The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 XNO certificate 1 Yes Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes ER/Outpatient 3 DOA မ 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) this eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending 1 Yes 2 No after death Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 00014168 What 15 aug 12-30-10 IND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Three Notch Rd MKCHANICSVILLE, and 201659 28/03 120BERT J. BAUKA, MD 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JAN 0 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 20, 2010 **Physician** 738 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min 1 □ M 2 😾 F Yrs Director 94 216-01-4135 3. 1916 Maryland Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Carroll Hampstead 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 3508 Schaefer Drive 21074 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 23.
Lry or other traumatic event, the Medical Example mater. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ If Yes, Give Specify. white 3 ☐ Widowed 4 ☑ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) manufacturer accounts payable clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Stull Lucinda Elseroad ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hampstead, Maryland 21074 3508 Schaefer Drive Jane Alban – daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 23, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Upperco, Maryland Emory U. M. Cemetery 2010 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licens 934 South Main Street Hampstead, Maryland 21074 M01072 w Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending as IF FEMALE: ed by the attendin detached for use If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ■ No 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 1 □Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No ပ 1 ☐ Yes 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation death. 1 ☐Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 Obrecht Road

State Registrar

TARLY X. Field MD 31. Date filed (Month, Day, Year)

			Please Type or Print in						10060		
			For State of Marylar		ent of Health ate of Death	and Mental F		2010	43069		
			Registrar Decedent's Name (First, Middle, Last)	Ochanoc	ato or Boatir	2. Date of			3. Time of Death		
	Physicia Medic		Betty Ann Murphy			Decen	ber	31, 2010	3:45 P M		
	Examin		4a. Facility Name (if not institution, give street and number)		ity, Town, or Location	of Death		1c. County of Death			
-	Funeval		Bethesda Health & Rehabilitati 5. Social Security Number 6. Sex 7. Age (In yrs.)	on Cntr Be	thesda	r 24 H <i>r</i> s. 8. Date of		Montgomer	y place (State or Foreign		
	Funeral Director		214-60-5640 1 M 2 X F 85	Yrs. Monti		Min. (Month,		925 Alab	itry)		
	nd now at.	٦	Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ty, Town or Location					10d. Inside City Limits		
	farylar 3a-fsl iffied	ecto		ckville					1 ☐ Yes 2 X No		
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Funeral Director	10e. Street and Number		Zip Code			Citizen of What Cour			
	th with ms 23 must	ner	199 Rollins Avenue #220		0852	ining (Chapity Van or I		ted State			
ယ	or ite		11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 🔏 No.	If Yes, s	pecify Cuban, Mexica	igin? (Specify Yes or I n, Puerto Rican, etc.)	NO-	14. Race - Americ Black, White,	etc.		
21215-0036	urs aft ural", Il Exa	Completed by	3 ☐ Widowed 4 X Divorced If Yes, Give Year or Dates.	1 ☐ Yes	s 2 ဳ No Specify	<i>:</i>		Specify: Cauc	pecify: Caucasian		
15-(72 hou n "nat ledica	nple	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's U (Give kind of life. DO NOT	work done during mos	st of working	16b.	16b. Kind of Business Industry			
212	within giene. er thar t, the M	Con	Elementary/Seconday (0-12) College (1-4 or 5+)	Housewife			Но	me			
pu	filed y	o Be	17. Father's Name (First, Middle, Last)	-	1	ner's Name (First, Mide	dle, Maide	n Sumame)			
ryla	should be file and Mental F is marked o raumatic eve	To	William Gray			1 Butler					
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, <i>Print</i>) Gretchen Tardell, daughter			er or Rural Route Nur ckaway, No					
Baltimore,	of Health a fitem 27 is			Place of Disposition (figure 1)	Vame of	Date	20c.	Location - City or To	own, State		
iii	ment tant l		I Duliai 2 (A Cremation 3 D Removal nomitotate	rt Lincoln	Cromatory	1/5/2011	Br	entwood,	Maryland		
B	Departiment Important		21. Signature of Funeral Service Licensee INN KOWE MOUOF			Center.			& Cremation		
-			23a. Part 1. Enter the disease, or complications that caused the deal			Pike, Rocl		e, maryia	Approximate		
	Physician/		shock, or heart failure. List only one cause on each line.					5	Interval Between Onset and Death		
	Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a	uence of):	ue Air						
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseq		ARTO	RY DIS	EA	56			
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	uence ot):							
	be executed sician and burial-transit		that initiated events resulting in death) Last C. Due to (or as a conseq	uence of):							
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Box 68760	eath certificate by attending physic d for use as the b	/Me	IF FEMALE: 23c. If yes, outcome of pregna	ancv				001.01. (1.11			
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rds	require been si should	etec				24a. W		,	psy findings available		
ecc	e has l	Completed				a	utopsy erformed?	prior to co	mpletion of cause of		
al B	ician: The la certificate ha	Be C	25. Was case referred to medical examiner?		26. Place of Dea	1 ∐ Y ath (Check only one)	es 2LLT	No 1 ☐ Yes	2 × No		
Vit.	Physic this ce al direc	မ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3		ursing Home 5 R	esidence	6 ☐ Other (Specify	·)		
n of	ding F h. After 1 funera	ate:	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 Yes 2		e how inj	ury occurred			
Division of Vital Records,	Atten ar deat ector: by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined determined	I ome, farm, street, fact		28f. Locatio		and Number or Rural	Route Number,		
Θ	ital or urs afte al Dir led in		building, etc. (Specify	"		City or	Town, Sta	te)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination)	n and/or investigation,	in my opinion, death of	ccurred at the time, da	te and pla	ce, and due to the car	use(s) and manner stated		
	To the within 2 To the сотрlе	Σ	only one) 3 Certifying Nurse Practioner: To the best of m 29b. Signature and title of certifier		29c. License number	e and place, and due to		e(s) and manner as st Date signed (Month, I			
	L		In Ben, und		0005	7124		1/3/11			
			30. Name and address of person who completed cause of death (Item								
	Stat	e -	Dr. Bao, 10110 Molecular Driv 31. Date filed (Month, Day, Year) 22. Registrar's Signa		ockville,	Maryland 2	20850				
	Registra		JAN 04 2011 Januar &	- FOREST	<u> </u>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2010 Robert Earl Monroe December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign Country) 1917 Washington 8. Date of Birth (Month, Day, Yo **June 14** Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Hours Year. 1 ▼M 2 □ F Director 93 Yrs 328-07-7009 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Director 1 Yes 2 K No Maryland Montgomery Kensington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 4 Orleans Terrace 20895 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married 2 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Caucasian If Yes, Give Year or Dates 1940-45 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) **Association** ssociation Executive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Duncan Daniel Monroe Arvilla Stockton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4 Orleans Terrace, Kensington, Maryland 20895 Pauline J. Monroe, Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Crematory 1/6/2011 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center
040 Rockville Pike, Rockville, Maryland 20852 21. Signature of Funeral Service Licensee 1040 Rockville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death week Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner Due to lor as a conse tience of e attending physician and if any, leading to immedicause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No 2 **X** No this certificate 1 Yes Division of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. injury 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifia December 31, 2010 D70505

Registrar

State

3

Rober

32. Registrar's Signature

8600 Old Georgetown Road, Bethesda, Maryland 20851

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Yuditskaya,

JAN 04

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 9 Month Physician/ 2034 Eydya Mezhebovskaya 2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day.) May 17 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 □ M 2 🗓 F Months 1914 Russia Director 212-49-8129 96 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. traumatic event, the Medical Examiner must be notified at Director Rockville 1 Yes 2 Y No Maryland Montaomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a U.S.A 20853 12630 Veirs Mill Road. Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ☐ Yes 2 🛛 No ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes Give "natural", White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than " Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Automotive is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Pinkhus Mezhebovsky Ester Chernyavskaya 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Boris Rekhtman - Grandchild 5701 Radnor Court. Bethesda. Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1
Department of I
Important: If its
any injury or or 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Judean Memorial Grdns: 12/31/2010 Olney, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licens 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury burial-traps that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician I be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate has 1 Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 IDOA 1 Yes ၉ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred After Natural injury 5 Pending 1 Yes 2 🗌 No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20Ner 15825 Shady Grove Rd., ONSTAN Rockville, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar		" State of N	larylar			te of D			vientai Hy	gier Reg.	2010	#36	12	
	D	. ,	Decedent's Name (First)	, Middle, La.	st)							2. Date of De	eath	Day Year	3. Time o	f Death	
	Physicia Medic		Suman		Mehra	<u>a</u>						Decemb	er	31, 2010	2:05	p_M_	
	Examin	er	4a. Facility Name (if not ins		street and number)			4b. Cit			on of Death			4c. County of Dea			
	Funeral		Casey Ho 5. Social Security Number	ouse 6.8	ex 7. Ac	ge (In yrs. i	last birthday)	If Und	KC er 1 Year	If Unc	ille der 24 Hrs.	8. Date of Bi	Montgomery f Birth 9. Birthplace (State or Foreign				
	Director		146-86-1382		□ M 2 X F	81_	Yrs.	Months	Days	Hours	s Min.	(Month, Di 11/23/	Day, Year) Country) 3/1929 India				
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-	n the la or 2	ᅙ	10e. Street and Number					10f. Z	ip Code				10g.	0g. Citizen of What Country?			
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36	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ D		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.				ecify Cubar 2 XNo			ecify Yes or No Rican, etc.)		14. Race - Am Black, Whi			
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Baltimore, Maryland 21215-0036	thin 72 ne. than "	Completed	Elementary/Seconday		College (1-4 or	5+)	(Give kind of work done during most of wo life. DO NOT use retired) Homemaker					ung		Dom	estic		
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/an	shoul and I is ma		19a. Informant's Name/Re	elationship (7				0	,					y or Town, State, Zip Code)			
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nor			1 Burial 2 Cre 4 Donation 5 D	mation 3x	Removal from State	• °	cemetery, cren	natory or	other place		1	2/2011		11s Chur		rainia	
altir	permit. Page Department Important: If any injury or once.		21. Signature of Funeral S			INAL	ional	Name a	and Addres	s of Fac	cility		Гга	IIS Chai	CII, VII	ginia	
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and the	Examiner																
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8760	tificate ng phy as the		IF FEMALE:	_												_	
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ds,	quires en sig ould b											1 🗆	Yes	2 □ No 3 □ F	robably 4X	Unknown	
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ion	tendin leath. or: Afi the fur	ifica	2 Accident	Pending Investigation Could not b	1			М	1 🗆 `	Yes 2	□ No						
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	al Certificate:	4 Homicide	determined	28e. Place of Inj building, et			eet, facto	ry, office			28f. Location (City or To		and Number or Ru te)	ral Route Numb	oer,	
	Hosp 24 hol Fune eted fil	Medical	(Check 2 I Me	dical Exam	sician: To the best of ner: On the basis of e se Practioner: To the	examinatio	n and/or invest	tigation, in	n my opinio	n, <mark>death</mark>	occurred a	t the time, date	and pla	ce, and due to the	cause(s) and ma	nner stated.	
	To the within To the comple	Σ	only one) 3 L Ce 29b. Signature and title of		se Practioner: To the	pest of m	y knowledge, c		orred at the c. License			ce, and due to tr	-	e(s) and marrier as Date signed (Mont			
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)		30. Name and add ess of						4116	Ma	rv.1 a-	d 2085	0				
	Stat		G. Coleman, 31. Date filed (Month, Day,	Year)	355 Piccar			OCKV	TITE,	ma	ryran	2003	U				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 25, 2010 Physician/ 4:50 P M William Matzkin Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery 209 Hardey Place Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Month: Hours New York o4//24/14922 092-16-8601 88 Director Usual Residence of Decedent I Hygiene. other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director MD Montgomery Rockville 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20852 United States 209 Hardey Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 K Yes 2 No WW-II Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 N Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Medicine Psychiatrist pernit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other traumotic event, the any injury or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 David G. Matzkin Anna S. Spizer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 313 Meadow Lane Merion Station, PA 19066 Richard A. Shapp-Nephew Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date ☐ Burial 2 Cremation 3 Removal from State 12/31/10 Falls Church, VA National Crematory 4 ☐ Donation 5 ☐ Other (Specify) M0116322 Name and Address of Facility Edward Sage Funeral Direction Inc 1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee 20 Den 1. Exert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Elevated Lipids, Pulmonary Thromboembolism, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Sick Sinus Syndrome, Hypothyroidism has autopsy performed? 1 Yes 2 No After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1 X Natural Accident Investigation hin 24 hours after death the Funeral Director: filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pleted (Check 3 🗆 only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34472 December 28, 2010 ress of person who completed cause of de 3a) (Type, Print) ath (Ite 10400 Connecticut Avenue, #206 Kensington, MD 20895 Lynne Diggs, MD 31. Date filed (Month, Day, Year) JAN 04 2011 2. Registrar's Siguature State Registrar

Amend Items 28tate of Maryland, Department of Health and Mental Hygiene For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ Cirilio Del CidMarquez 13/2M 201 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1108 Wentworth Drive Oxon Hill Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** Country) El Salvador (Month, Day, Yea ar 25, 1 227-35-3217 1 👿 M 2 🗆 F Months Days Hours Min. 64 โ946 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Md. Prince Georges Oxon Hill 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 1108 Wentworth Drive 20745 U. S. A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 1 🏿 Yes 2 🗆 No Specify: salvadoran Specify: Hispanic "natural", Completed 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours permit. Page 1 and 2 should be filed within 72 hours pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Cleaning Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria Isabel Del Cid Juan Marquez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 22303 5541 Janell Street Alexandria, Va. Nelson Del Cid (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ▼Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 4, 201 Annandale, Va. Pleasant Valley 22. Name and Address of Facility
W. H. Bacon Funeral Home, Inc.
3447 14th Street, N.W. Washington, Signature of Funeral Service Licensee 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Asphyx1ATION Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No o Month Dav ate has been signed by the a page 2 should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes

Y☐ No 24a Was an autopsy performed certificate within 24 hours after death.

To the Funeral Director: After this certific Gompleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examinor? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: POUND: 1 🗌 Natural 5 Pending Subject hanged himself 12/28/2010 12:47 PM 1 Yes 2 X No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1108 Wentworth Dr. Oxon Hill, MD determined 4 Homicide home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 vs/e-31. Date filed (Month, Day, Year) . Registrar's Signature State 2011 JAN 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State
Registra AMEND#29 doer MD, 1/12/11; EWW, McCo Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 12/20/2010 JAMES WILLIAM MARR, JR. 1127 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Washington Adventist Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Days Hours Min. Months 712/193 Director 214-28-9718 78 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔀 No or 28a-f MD Silver Spring Montgomery 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral 102 Ritchie Avenue USA 20910 items within 72 hours after death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ⚠ No Black, White, etc. þ 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black If Yes. Give "natural", 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools llth Be other traumatic event, filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ should be James W. Marr, Sr. Katie Pratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Roslyn Marr/daughter 102 Ritchie Avenue, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 01/05/11 Sandy Spring, MD 4 Donation 5 Other (Specify) orial Cem 22. Name and Address of Facility Snowden Funeral Home Eutheral Service Licenses Signature 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, complication caused the death not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one ca Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): -transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Exar and Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical y the attending physic ما بما for use as the br Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No been signed by the should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 □ No 3 □ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 24 No has page 2 death? certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X No 1 XInpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending 2 🗌 No 1 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cer 29d. Date signed (Month, ၉ 260096 12/20/18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

David Jacobs, 31. Date filed (Month, Day, Year)

JAN

04

ZUI

7600 Carroll Avenue,

\$2. Registrar's Signature

Takoma Park, MD 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 20 Year to Physician/ 12 3:14 PM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore of Maryland Medica Date of Birth 9. Birthplace (State or Foreign Sex 1 X M 2 □ F **Funeral** Hours Months Days Min (Month, Day, Year) Country) 60 217-51-1064 **Director** Russia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 72 hours after death with the Maryland Director 1 Tes 2 X No Montgomery Village Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 20886 18029 Royal Bonnett Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Medical Surgeon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ludia Akulenko Isaac Mirlas permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marks any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aleksandr Mirlas - Son 21851 Knob Hill Place, Ashburn, Virginia 20148 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/24/2010 | Rockville, Maryland 4 Donation 5 Other (Specify) Parklawn Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MOUZE <u> 11800 New Hampshire Ave., Silver Spring,</u> MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Hemolyte Microangiopathic Medical resulting in death) Examiner Parpara retractory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) dansit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypothyroidush 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ancer Sp chemetherapy and radiation autopsy performed? death? 5 years Therapy 1 Yes 2 No sungery Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗌 No 1 🗶 Yes မ 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 2010 20 NPI 1295050748 Scott Berry MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 2010 29

Registrar

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month mc QUEEN 24 AM AMES FREMBER 2010 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner WASHINGTON ADVENTUT HOSPITAL PARK MONTGOMER (A (Lom A 8. Date of Birth 11/9/1939. Birthplace (State or Foreign if Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 1 A M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Como 1 (Month, Bay, Year) 39 Hours 71 578-56-1752 Director Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State the Medical Examiner must be notified at Director 1X Yes 2 No None Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20020 USA 2515 R Street SE #127 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry completed) (Specify only highest Bureau of Engraving and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) 12th College (1-4 or 5+) Federal Government Forklift Operator Be Ukn. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mariah Ukn. Wife 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $15\ R\ Street\ SE\ \#127\ Washington,\ DC$ Margaret Ruger McQueen/ item 27 i injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ft. Lincoln 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 XBurial 2 Cremation 3 Removal from State 12/22/10 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. cc0278 Georgia Ave. NW Washington, DC 20011 23a. Part 1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition ADVANCED Physician/ AND Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) ng physiclan and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physiclan Physician/Medical Division of Vital Records, P.O. Box 68760 nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Pregnant at time of death detached the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed l Ş 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed has death? certificate 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cu clos MU DECEMBER 13 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll Avenue, Takoma Park: MD, 20912 ALOW 7600 31. Date filed (Month, Day, Year) State 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryla		artment of I rtificate of			eg. No.		4.30		
	Physici	an	Decedent's Name (First, Middle, Last PHILIP NOW					Month DECEMBER	Day 29,	2010	5:45	A M	
حزث	/Medic		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of De			4c. County of Death			
- Species	Examin	ier	HCR MANOR CAR			SILVER	SPRING		MONT	rgomer	Y.		
	Funeral Director		5//-54-8089	ex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days		Irs. 8. Date of Birth (Month, Day SEPTEMBER	, Year)	9. Birthp Court 2 WASHI	lace (State or htry) NGTON,	Foreign DC	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation				1	0d. Inside Cit	y Limits	
	Maryl -f sho fied a	tor	MD MONTGOME	RY S	ILVER S	SPRING					1 ★ Yes	2□No	
	or 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	f What Cour	ntry?		
	23a ust b	ral	14155 CASTLE BLVD			209				USA ace - Americ	on Indian		
36	172 hours after death with the Maryland "natural", or items 23a or 28a-f show dhal Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in Armed Forces? 1 ★ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul 1☐ Yes 2☑ No		(Specify Yes or No- erto Rican, etc.)	Spec	lack, White,			
215-0036	2 hou latura	ted	15. Decedent's Ec	ducation	16a. Dece	dent's Usual Occu	pation	working I	16b. Kind of	Business/Inc	dustry		
712	d within 72 ho giene. r than "natul th Medi al	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	ed)	VOIKING	COVEDA	יייניטאני			
7	filed wi Hygien other th	Sol	12th		CI	LERK	18 Mother's N	Name (First, Middle,	GOVERN				
⊆	e d stal	Be c	17. Father's Name (First, Middle, Last, PHILIP CARTER	'				ERTRUDE NO		штој			
>	should and Men marke	우	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Stree	t and Number or	Rural Boute Numbe	r City or Tow	n, State, Zip	Code)	2000/	
Š	s 1 and 2 shou f Health and M tem 27 is mar other traumat		MONICA BULLOCK -	DAUGHTER	14155	CASTLE	BLVD. A	PT. 403, S	SILVER	SPRIN	G, MD	20904	
e,	es 1 a of Her I tem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Location	n - City or To	own, State		
Ĕ	Pages ment of ant: If it lury or o		4 □ Donation 5 □ Other (Specif	y) QUA				/06/2011				OVER -	
Baitimore,	permit. Pag Departmen Important: any Injury once.		21 Signatury of Funeral Service Lice	WOM	7 1	6 KENNED	Y STREE	JOHNSON & T, NW, WAS	SHINGTO		2001	.1	
	5.2		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.	ath. Do not en	ter the mode of dy	ing, such as card	diac or respiratory ar	rest,		Approximate Interval Bety Onset and D	een Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. END STAGE		DISEASE							
	/Medical Examiner			Due to (or as a conse	equence of):								
	を急	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):								
	ate be executed nysician and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
Ç	be executed ician and burial-transit		resulting in death) Last	Due to (or as a conse	equence of):								
-	ate be hysici the bu	lical		d									
X DX	ding p	/Mec	IF FEMALE:	23c. If yes, outcome pf preg	nancy				224 [Date of deliv	op.		
O. Box	the death certificat y the attending phy Iched for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	⊒Ectopic pregnan ⊒ Other (s <i>pecify)</i>	су			Month		Year	
cords, P	w requires that the de been signed by the a should be detached i	þ	Part II. Other significant conditions of	contributing to death but not re	esulting in the u	inderlying cause g	iven in Part I.		bacco use co ′es 2 No				
Hec	sician: The law re certificate has bee irector, page 2 sho	Completed								b. Were auto prior to co death? 1 \(\sum Yes	opsy findings ampletion of ca	available ause of	
	ian; ertifica ctor, p	Be C	25. Was case referred to medical examiner?					Death <i>(Check only or</i>					
0 70	hysic this ce	일	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	<u> </u>	III 3 DOA		g Home 5 ☐ Resid			fy)		
	ding Physician;). After this certific funeral director,	iio	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	We	uryat ork?]Yes 2 □ No	28d. Describe h	ow injury occ	curred			
	or Attentiter death trer death lirector; n by the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined					28f. Location (S City or Tow	treet and Nur n, State)	mber or Run	al Route Num	ber,	
	Hospita Hours Funera tely fille	Medical C		nysician: To the best of my k niner: On the basis of exami and manner stated.								;)	
	To the Within 7 To the comple	Me	29b. Signature and title of certifier	n 0	//	29c. Licer	se number		29d. Date sign	ned (Month,	Day, Year)		
			alien I	L. Sega	Low	/ D522	261		12/29/2	2010			
2	3		30. Name and address of person who				3.5	1 1 0000	26	-			
			Alan Segal, MD, 1 31. Date filed (Month, Day, Year)	517 Hugo Circ	Le, Si.	Lver Spri	ng, Mar	yrand 2090	סכ			,	
	Sta Registr		JAN 1 2 2011	Laure A	ale								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ \mathbf{a}^{M} Thanh Van Ngo 9:30 Dec 30 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days Hours (Month, Day, Year) 1**X** M 2 □ F Min. Country) Vietnam Director 577-06-3458 61 Jun 1949 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 XNo MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11565 Sullnick USA Way 20878 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2X No 21215-0036 1 Yes 2x No Specify Specify Asian 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Highland House Wes Tech <u>Maintenance</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland ည Dao Thi Ngo Phat Van Vo 19a. Informant's Name/Relationship (Type, Print)
Nhan Cao/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11565 Sullnick Way, Gaithersburg, MD 20878 Department of Health Important: If item 27 any injury or other to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1/2^{Date}1 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory Alexandria, 4 Donation 5 Other (Specify) Prancis J. Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Licenses Spring, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death acute myocardia Immediate Cause (Final infarction Physiciani 5 minutes disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner arrhythmia 45 minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner physician and stree burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate I 2 🗌 No 1 ☐ Yes 2 🜠 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🏲 No မ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate; injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident I Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title o 29d. Date signed (Month, Day, Year) WW 2010 C D068488 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Median center Dire, Rockville, Maryland 20850 MD Registrar's Signa State 4 Registrar

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30,

DECEMBER

ANH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43080 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:55am Edward Warren Nylen December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Buckingham's Choice Adamstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 1 🗶 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** (Mogth, 93 / 1922 washington. Director 577-34-1278 88 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or rother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Adamstown Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3200 Baker Circle 21710 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Attorney Private Law should be filed with and Mental Hygien 7 is marked other the 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elin Marie Skoog Arthur Howard Nylen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7025 Augusta National, Fayetteville, PA 17222 Donna L. Lavenburg - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cem. 12/31/2010 | Silver Spring, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLITIS Physician/ CLASTRIDIUM DIFFICILE disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) re attending physician and for use as the burlah-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTA BLEZD 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 61 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law **Director:** After this certificate has In by the funeral director, page 2. page 2 autopsy performed' death? 1 Yes 2 No 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29c. License number **D** 21936 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS WHISON DR FREDERICK, NO 21702 BNELSON, £50 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 9:30 P M 2010 December Physician/ Betty L. Parker Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Germantown 19525 Gunners Branch Rd. Apt. Birthplace (State or Foreign Country) 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) (Month, Day, Year) Social Security Number 6. Sex **Funeral** 1 🗆 M 2 🔀 F Carolina 1928 North Yrs. 82 Director 227-32-6428 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10b. County 10a, State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Germantown Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 20876 19525 Gunners Branch Rd. Apt. D Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc 11. Marital Status Armed Forces? Black Yes 2 No Specify 1 Never Married 2 Married ð If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 3 XWidowed 4 Divorced Completed 16b. Kind of Business Industry Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Private Domestic 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lena Smith Silas Glenn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Germantown, Md. 19525 Gunners Branch Rd. #D Sandra L. Coleman - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place)
Arlington National Jan. 20, 2011
Cemetery 20a. Method of Disposition 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Arlington, VA 4 Donation 5 Other (Specify) 2. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Se vice Washington, DC 4001 Benning Road NE er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leart failure. List only one cause on each line. Approximate Part 1 Exter the disease, or shock, or leart failure. List of Interval Between Onset and Death <u> Altheroscleotic Heart Disease</u> Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Seizure Disorder Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Dementia Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of): Failure To Thrive Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery IF FEMALE: Year 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown δ Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 has page 2 24 hours after death. Funeral Director: After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical filled in by the funeral director, Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify, examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 2 🖪 No ပ 28d. Describe how injury occurred 28c. Injury at work? 28b. Time of 28a. Date of injury (Month, Day, Year) 27 Manner of Death Certificate: injury 1 Natural
2 Accident 5 Pending 2 No 1 Yes Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide
Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed within 2

To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2011 January 7, D53691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite # 110 Rockville, Md. 20852 200 Tower Oaks Boulevard MDAjay Reddy,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 1 2011

32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 20 TO 5:30 P M Viola M. Powell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brinton Woods Nursing Home Sykesville Carroll 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** Social Security Number Hours Min. 1 DM 2 X *472,P*1914 96 MD Director 218-01-1110 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No MD Carroll Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6093 Oklahoma Rd. 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: 3 Nidowed 4 Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Housewife Her Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ida Skibinska Felix Zezulinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent G. Powell/Son 1240 Saddleback Rd., York, PA 17408 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State Holy Rosary Cemetery | 12/24/2010 | Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Burrier-Queen Funeral Home & Crematory, P.A. 1 1212 W. Old Liberty Rd., Winfield, MD 23. Part 1. Inter the disease, or complications shock or heart failure. List only one cause sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death edia / Cause (Final Physician, KIMARY SONGRATIVE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No been signed by the atte Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 1 Yes 2 No After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death eck only one) examiner? Other 2 1 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

MASS

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State

Registrar

Registrar's Signature

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31. Date filed (Month, Day, Year)

DEC 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrary No. 1/13/11, BMW, McCo 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Freyda Peresetskaya 2010 December 3:40 а Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth **Funeral** (Month, Day, Year) 1 M 2 XF Months Days Hours Min. 212-37-6426 Director 86 02/02/1924 Ukraine Usual Residence of Decedent ms 23a or 28a-f shor must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director 1 √2 Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6105 Montrose Road 20852-4881 ral", or items ! within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 1 and 2 should be filed within 72 hours after the ath and Mental Hygiene. Item 27 is marked other than "natural", other traumatic event, the Medical Exal Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Pharmacist Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael Shatenshteyn Genda "unknown" 19a. Informant's Name/Relationship (Type, Print)
daughterNatalya Peresetsky, in-law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 319 North Van Buren Street, Rockville, MD 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Garden of Remembrance Memorial Park 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/02/2011 Clarksburg, Maryland Signature of 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 Rockville Pike, Rockville, Maryland 20852 meral cervice Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Advanced Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Lindentying Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-tremits the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, ြု 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No s after death. Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury M Investigation Accident filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours To the Funeral C Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 1 Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Farle 12-31-2010 D0064871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20852 Montrose Mina Fazli, MD 6105 Rockville Rd 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 For State AMFND#23eperMD,174/11,EMW,MbCo Registrar Certificate of Death Rea. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 29, 2010 3:10 PM Georgia Howard Pometto Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Examiner Regional Hospital Laure Laurel 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number North Carolina Days 88722/1920 Funeral Months Hours 1 □ M 2 🕱 F 90 237-28-9138 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State Director 1 Yes 2 X No Silver Spring Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 3112 Gracefield Road, Park View #414 20904 Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Specify. Specify: Caucasian Baltimore, Maryland 21215-0036 Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Operation Review Assistant 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Mary Ward ೭ Robert Lee Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1129 Plantation Lakes Circle, Chesapeake, VA 23320 Cheryl Ann Marker - Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 01/03/2011 Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Lizensee 11800 New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final HYPOXId Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Acute Respiratory Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Infarction and nard Myocardial Physician: The law requires that the death certificate be executed Due to (or as a conseque resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ Live Birth 2 - Fetal death Day Year Month in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown has been signed by the a g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2X No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has been 24a Was an autopsy performed Yes 2 1 Tyes page 26. Place of Death (Check only one) 25. Was case referred to medical Be funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 🗌 Yes ည 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: iniury Hospital or Attending 24 hours after death. 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after death To the Funeral Director: / completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0012962 December 29, 12 Hospital Laurel Regional 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Zorayda 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 40AM SA comber Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Spring Randolph Hills Nursing Center Silver 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Country) Korea Year 19<u>13</u> June 06, 1 □ M 2 🕱 F Months Hours Min Yrs Director 97 231-25-6518 Usual Residence of Decedent 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗆 Yes 2 🔀 No Montgomery Silver Spring MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20902 4011 Randolph Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. th and Mental Hygiene.
27 is marked other than "natural", traumatic event, the Medical Exa Specify: Asian 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic avant æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Maria Yeon Doo Hwan Kim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sam Moonseek Park/Son 12128 Kara Lane Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairfax MemorialPark | Jan 05,2011 | Fairfax, VA 21. Signature of Funeral Service 22. Name and Address of Facility Fairfax Memorial Funeral Home M00956 9902 Braddock Rd., Fairfax, VA 22032 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, it any racing to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit ears Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death n signed by the a ld be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? Yes 2 No death? 1 ☐ Yes 2 🕱 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 X No Be 26. Place of Death (Check only one) Hospital: ဂ္ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director. 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0021033 recember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3000 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item per doc , 5 per fh g912 2-3-11 vt
State of Maryland / Department of Health and Mental Hygiene 2 | | | For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Muhammad Sulaiman Qureshi 2. Date of Death 3. Time of Death DECEMBER Physician/ 11:47 PM Oureshi Muhammad Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Examiner Cheverly Prince Georges Hospital Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 🖾 M 2 🗆 F Days Hours Min. (Month, Day, Year) 2/25/1940 Country)
Indi 70 -72-4023 Director Usual Residence of Decedent or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 3903 Corbin Place 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", 3 Widowed 4 Divorced Asian Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Publication Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Muhammad Umar Qureshi Zubaida Qureshi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 8416 N. Sharon Ave. Fresno, CA 93720 Atif Oureshi/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 15 Burial 2 Cremation 3 Removal from State Maryland National12/31/10 Laurel, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Latney's Funeral Home, Georgia AVe. NW Washington, DC 20011 cc0278 3831 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARRHYTHMIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death the 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has i autopsy performed?
Yes 2 No 1 Yes 2 No this certificate ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pendina within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my 29b. Signature and title∮of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) GRIFFIN HOSPITAL DAV15 3001 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 31, Month **Physician** Richard Ellis Ranoull 3:45 рм December 2010 /Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Sykesville Carroll Nursing & Rehabilitation Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Sep 17, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours M 2 ☐ F 73 Maryland 213-42-4284 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanther must be notified at once. Sykesville 1 ☐Yes 2X No Carroll Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 1442 Buckhorn Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Y No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. white Be Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Dairy Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellis Columbus Ranoull Emma Catharine Baker ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2710 Wakefield Valley Road, New Windsor, MD 21776 Carol L. Bassler, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Lutheran Cemetery 01/04/2011 Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licenses 91 Willis Street, Westminster, MD 21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 donknown 1 ☐ Yes 2 ☐ No should I 24b. Were autopsy findings available prior to completion of cause of death? cate has autopsy performed 2 1 No 1 □Yes 2 **H**No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 - No 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Japital o. -4 hours after des. -eral Director: Andrin by the fur 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 🖃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapper stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe 2011 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) as) HIR CC trar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	i Maryian		artment of tificate of		and iv		Glene Reg. N	2011	43088
	Dhysicia	-/	1. Decedent's Name (First, Middle, Las	st)						2. Date of De	ath	ay Year	3. Time of Death
	Physicia Medic		ROBERT					1				er 2	27, 2010	12:33p ^M
	Examin	er	4a. Facility Name (if no					4b. City, Town,		of Death			c. County of Death	
	Funeral		Peninsula 5. Social Security Nurr			al Cent 7. Age (In yrs. Is		Salisbu If Under 1 Yea	r If Under		8. Date of Birt	th	icomico 9. Birth	place (State or Foreign
	Director		231-58-402	22 1	X M 2 □ F	64	Yrs.	Months Day	s Hours	Min.	Month, Da Sept 1	y, Year)	1946 Virg	inia
	land show dat		Usual Residence of Do	ecedent 0b. County		10c City	y, Town or Lo	cation						10d. Inside City Limits
	arylan a-f sh fied a	Director		Worceste	r		7 Hi ll	cation						1 ☐ Yes 2 🕱 No
	or 28 e noti		10e. Street and Numb					10f. Zip Code				10g. C	itizen of What Cou	ntry?
	with s 23a ust b	Funeral	7116 Ayres	s Lane R	oad			21863				US	A	
	death item		11. Marital Status		12. Was Dece Armed For	dent Ever in U.S	3. 13.	Was Decedent of f Yes, specify Cu	Hispanic Ori ban, Mexicar	gin? (Spec	cify Yes or No- Rican, etc.)		14. Race - Americ Black, White,	
99	after Il", or xamii	d by	1 Never Married 3 Widowed 4		1 \(\sum \) Yes If Yes, Give	2 X) No e		I ☐ Yes 2 🔽 N	lo Specify:				Specify.White	
Maryland 21215-0036	within 72 hours after death with the Maryland gient ethen "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed by		15. Decedent's E		ites.		dent's Usual Occi				16b. k	Kind of Business In	
215	in 72 e. nan "r	dmc	(Specification (Speci	fy on <i>ly highest gr</i> day (0-12)	ade completed) College (1-	-4 or 5+)	Ìife. D	kind of work don O NOT use retire	e <i>du</i> ring <i>m</i> osi d)	t of workin	ig	_	7.	
7	d with lygien ther th	d)	8				Repai	man					ltry	
and	ntal H red ot ed ot	년 B	17. Father's Name (Fir.								(First, Middle, arpente		Surname)	
چ	ould k		19a. Informant's Nam		vpe. Print)	-	19h Mailir	a Address (Stree		-			r Town, State, Zip	Code)
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner.		Patricia H										MD 2186	
ğ.	of Heal of Heal fitem ?		20a. Method of Dispos		D		lace of Dispo	sition (Name of natory or other p	ace)	D	ate	20c. L	ocation - City or To	own, State
Ĕ	Page 1 ment of tant: If it ury or o		1 Burial 2 4 Donation 5	Other (Specif	y)	Goods	vill Met	hodist Ca	metery '	12/31	/2010	Pocc	omoke Cit	y, MD
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funer	ral Service Licens	see		H	Name and Add	ress of Facilit Funera	Ho	me, Pro	fess	ional Assoc	ciation
		-	23a. Part 1. Enter the	disease or com	An plications that c	aused the death							MD 21851	Approximate
	Physician/		shock, or heart f Immediate Cause (Fir	ailure. List only o	ne cause on ear	ch line.							16	Interval Between Onset and Death
	Medical		disease or condition resulting in death)		a. Due to (or as a consequ	ience of):	5 000	03/1	260			- '	TINUIES
	Examiner		Sequentially list cond	litions	ARTE	PIO S	LERGY	IC CAG	LDIOV	ASCU L	AR &	158	745E	YRS
	p ë	Examiner	if any, leading to imm cause. Enter Underlyi	ediate ing		or as a consequ								
	and and I-trans	Exan	Cause (Disease or iin) that initiated events resulting in death) Las		c. Due to (or as a consequ	ence of):							
_	icate be executed physician and s the burial-transit	ledical		L	d									
3/60	ficate g phy as the	Medi			d									
χο ×	h certifi tending r use a	<u></u>	IF FEMALE: 23b. Was decedent pri in the past 12 mo	egnani	23c. If yes, outo	come of pregna Birth 2 🗆 Feta	ncy I death 3 🗆	Ectopic pregna	ncy				23d. Date of deliv	
ROX	I aw requires that the death certificate been signed by the attending in 2 should be detached for use as	Physici	1 Yes 2 I		4 Pregr 9 Unkn	nant at time of d own	leath 5 [Other (specify)					Month	Day Year
л Э	nat the	F.	Part II. Other significa	ant conditions of	ontributing to de	eath but not res	ulting in the u	nderlying cause	given in Part	1.	23e. Did to	bacco	use contribute to the	ne cause of death?
<u>'</u>	requires that the been signed by t should be detach	od by									1 🗆 '	Yes 2	□ No 3 □ Pro	bably 4 Unknown
0.0	w requ	Completed									24a. Was a		24b. Were auto	psy findings available impletion of cause of
ě	The la	Mo									autop perfo 1 Yes	rmed? 2 X N	death?	
<u> </u>	sician: The la certificate ha irector, page 2		25. Was case referred examiner?		Unonital:			1-	Place of Deat	th (Check				
<u> </u>	Physic this o	၉	1 Yes 2 1	No	Hospital: 1 🔲 I 28a. Date o	Inpatient 2	ER/Outpatier 28b. Time of	t 3 🗆 DOA					6 Other (Specify	()
Division of Vital Records,	ding th. After funer	cate		5 Pending Investigation	(Mont	h, Day, Year)	injury		ork? ⊒Yes 2 🗍		8d. Describe h	ow injur	ry occurred	
<u>s</u>	After or dea ector: by the	Certificate		6 Could not be determined	28e. Place			eet, factory, office					nd Number or Rura	Route Number,
2	= 0	- 1			buildin	ig, etc. (Specify)	'				City or Tow	n, State		
	Hospi 24 hou Funer ted fill	Medical	(Check 2	Medical Exami	ner: On the basi	s of examination	and/or invest	igation, in my opin	nion, death oc	curred at t	he time, date a	nd place		use(s) and manner stated
	ithin 2 of the omple		only one) 3 29b. Signature and title	7	e Practioner: T	o the best of my	knowledge, o		the time, date	and place			s) and manner as state signed (Month,	
	= 3 = 8		1/1/	Jan	t	wo			9025	56				- 2010
		ŀ	20. Name and address	of person who o	ampleted source	of dooth (Itam	23a) (Timo E							

10 E.T.

State Registrar J. G. Santiano – 100 Eighth St., Pocomoke City, MD 21851

31. Date filed (Month City 9 2010)

32. Jegistrar's Signature

J. J. G. Santiano – 100 Eighth St., Pocomoke City, MD 21851

			Please		nt in Black Ir aryland / Depa				_	43089
		•	For State Registrar	Oldio of W		tificate of L			eg. No.	40000
	Physicia	n/	Decedent's Name (First, Middle, La Lubie	STancil				2. Date of Death Month	r 30, 2010	3. Time of Death 2:34 A. M
	Medic Examin		4a. Facility Name (if not institution, give				r Location of Death		4c. County of Deat	th
~ ·			Holy Cross Hosp 5. Social Security Number 6. S		e (In yrs. last birthday)	Silv If Under 1 Year	er Spring	8. Date of Birth	Montgon	thplace (State or Foreign
	Funeral Director			X]M 2 □ F	84 Yrs.	Months Days	Hours Min.	(Month, Day, April 6	1926 Nort	ch Carolina
	show dat	to	10a. State 10b. County		10c. City, Town or Loc	cation				10d. Inside City Limits
	Mary 28a-f	irec	Maryland Montgon	ery	Silv	er Sprin	g			1 X Yes 2 □ No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 12325 New Hamps	hire Avenu	.e	10f. Zip Code 20 9	904	1	Og. Citizen of What Co United Sta	· ·
	items	Fun	11. Marital Status	12. Was Decedent B	Ever in U.S. 13. V	Vas Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	al", or	d by	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates U	No WWII	☐ Yes 2 X No				Lack
21215-0036	2 hours "natur idical I	Completed	15. Decedent's E (Specify only highest gi	ducation	16a. Deced	lent's Usual Occup	pation during most of work	ina	16b. Kind of Business	Industry
121	ithin 7; ene. • than	Com	Elementary/Seconday (0-12) 12th grade	College (1-4 or 5	ife. DO	O NOT use retired) ctrician			Constru	iction
2 pر	filed w al Hygi I other vent, I	Be	17. Father's Name (First, Middle, Last)				1	e (First, Middle, M		
ylar	Menta Menta narked	입		ncil	Т		Della	Mae		(unknown)
Maryland	2 shouth and the and 27 is not traum.		19a. Informant's Name/Relationship (i		- 1				City or Town, State, Zi _l .e , Marylan d	
ore,	of Hea of Hea fitem		20a. Method of Disposition		20b. Place of Dispo				20c. Location - City or	
Baltimore,	. Page tment tant: It jury or		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	(Y) a	Riverdal	e Park Cı	rematory		Riverdale,	
Ball	Depart Depart Impor any in		21. Signature of Funeral Service Picce	B.						Morticians, con,D.C.20011
	Physician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line	i the death. Do not ente e. osclerotic				it,	Approximate Interval Between Onset and Death 1 yr •
	Medical Examiner		resulting in death)	a	a consequence of):					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):			-		
	be executed sician and burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
0	be exe sician a burial-	हु	resulting in death) Last	Due to for as	a consequence or.					
876	tificate ng phy: as the	Medi	IF FEMALE:	- u						
P.O. Box 68760	ath certificate be ex attending physician for use as the burial	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnant	су		23d. Date of de Month	livery Day Year
O. B	the de by the ached	hysi	9 Unknown	9 Unknown	-					
s, P.(requires that the de been signed by the should be detached	by	Part II. Other significant conditions of Chronic Kidn	_	_	nderlying cause gi	iven in Part I.		acco use contribute to s 2 □ No 3 □ P	the cause of death?
ord	law requ has beer je 2 shou	Completed	Hypertension					24a. Was an		topsy findings available completion of cause of
Rec	l Physician: The lav H this certificate have eral director, page 2		Diabetes Mel	liutus				perform 1 \(\sum \) Yes 2		s 2 No
/ital	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 X ER/Outpatier	Lau	lace of Death (Chec	/ - /	nce 6 Other (Spec	16.1
Division of Vital Records,	ding Phy th. After this funeral d	te: To	27. Manner of Death	28a. Date of inju	ry 28b. Time of		ry at	28d. Describe hov		
ion	ttendir death. tor: Af the fu	Certificate:	1 A Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not I	n		M 1 □	Yes 2 □ No	005 1 11 404	- 1 - 1 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	
)ivis	al or Al s after l Direc d in by		4 Homicide determined	building, etc	ury - At home, farm, stre c. (Specify)	еет, тастогу, описе		City or Town,	eet and Number or Ru State)	rai Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exam	iner: On the basis of e	my knowledge, death o xamination and/or invest best of my knowledge, o	tigation, in my opini	ion, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated.
	To the within 2 To the сощре	Σ	29b. Signature and title of certifier	se Practioner: 10 the	best of my knowledge, c	29c. Licens			9d. Date signed (Mont	
			Disto.	_		D28			January	4, 2011
12	-1		30. Name and address of person who Ravi Passi ;	·	eath (Item 23a) (Type, F		Shady Gr ille, Mar		l; Suite 13 20850	30
	Stat Registra		31. Date filed (Month, Day, Year) JAN 1 2 2011		ar's Signature	ROCKV	TITE, HIGH	yrunu Z	2030	
	negistra	या	UNIT A CULT /		7					

P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I **Division of Vital**

68760

Box (

State Registrar

Medical

29a. Certifier

29b. Signature and title of certific

AJAY

BEHARI 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

han

200

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MEMARIAL AVE

064408

29d. Date signed (Month. Day, Year)

WESTMINSTER MODIIST

29/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:20 PM Stauffer 2010 Kevin Lewis De<u>cember</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 26169 Three Notch Road Mary's Mechanicsville Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 1 ፟፟ M 2 □ F 2010 Director December 19, Maryland N/AUsual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 Yes 2 No St. Mary's Mechanicsville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö er than "natural", or items 23a or the Medical Examiner must be Funeral 26169 Three Notch Road USA 20659 death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify. Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 0 <u>Never Worked</u> and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, ည Department of Health and Ment.
Important: If item 27 is marked any injury or call. Gladys May Stauffer Bryan Scott Stauffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26169 Three Notch Road, Mechanicsville, MD 20650 Bryan Scott Stau<u>ffer / Father</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loveville Mennonite 20a. Method of Disposition 20c. Location - City or Town, State Date December 24. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Loveville, Maryland Cemetery Signature of Funeral Service bicens 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner FPH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician s the burial Physician/Medical P.O. Box 68760 ding IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No ó Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 읻 this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work?
1 Yes 2 No X Natural 5 Pending Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number DECEMBER 23, 2010 63L

State Registrar

31. Date filed (Month, Day, Year)

Sheth,

ss of person who

MD

30. Name and add

Amit

completed cause of death (Item 23a) (Type, Print)

22878 Three Notch Road, California, MD 20619

				Please	Type or Pri	nt in Bl	ack In	delible	e Ink	. Ensure	All Copies	s Are L	_egible	10000	
			For Ammened State Registrar			ary awst	Cert	irtment tificate	of D	eath	VIепіаі пу	gienę Reg. No.	UIU	40074	_
	Physicia Medic		1. Decedent's Name (Firs		trickhouse	er					2. Date of Dea Month December		, 2010	3. Time of Death 11:00 PM	
120	Examin Funeral Director		4a. Facility Name (if not in 5858 Bow 5. Social Security Number 103 19 574	ers Ro	d.	e (In yrs. last :	4b. City, Town, or Location of Death Taney town Vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. 2 / 12						Co	o11 rthplace (State or Foreign	
	Herel Basidana of Dandark										12/12/1	1920	na.	10d. Inside City Limits	1
	ne Maryla or 28a-f s notified	Funeral Director	MD 10e. Street and Number	Carro	011	Γ	Taney	town				10a Citize	en of What Co	1 ☐ Yes 2基 No	$\frac{1}{2}$
	ath with the sms 23a commerce.	uneral	5858 Bo		Rd.	ver in U.S.	13 W	21	787		ecify Yes or No-	USA	. Race - Ame		$\frac{1}{2}$
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Fı	1 Never Married 2	2 X Married Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No 46-1	47	☐ Yes 2	x №		Rican, etc.)		Black, Whit		
Maryland 21215-0036	thin 72 hou sne. than "nat the Medica	Completed by	15. (Specify o. Elementary/Seconday	Decedent's Ed only highest grad y (0-12)	ducation de completed) College (1-4 or 5		Ìife. DO	ent's Usual ind of work NOT use i Sal	(done du retired)	uring most of worl	king	(4)	of Business	-	
and 2	oe filed wit intal Hygie ced other cevent, th	ര	17. Father's Name (First, I		trickhou	ser	<u>rgg</u>	Sal	-	18. Mother's Nan	ne (First, Middle, n J. Fu	Maiden Sui	_	ales	1
Mary	2 should be the and Me 27 is mark traumation		19a. Informant's Name/R	Relationship (Typ	pe, Print) Wife	1		-		nd Number or Rui	ral Route Numbe	r, City or To		ip Code) 17 8 7	-
Baltimore,	age 1 and ent of Heal nt: If Item 2 y or other		20a. Method of Disposition 1 X Burial 2 Cr 4 Donation 5	emation 3 🗆	Removal from State	20h Plac	e of Disnos	ition (Name	e of	emetery 1	Dato	20c Loca	ation - City or	r Town State	1
Baltir	permit. P Departm Importar any injur		21. Signature of Euneral S			- Ar	22.	Name and	Address	s of Facility	I		PA	17340 ittlestown	-
	Physician/ Medical Examiner		23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	sease, or compline. List only on	a. Due to (or as a	5 consequence	o not enter	the mode	of dying					Approximate Interval Between Onset and Death	
0	be executed sician and burial-transit	cal Examiner	Sequentially list condition of any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	rate /	b. Due to (or as a	· ·	ce on.						7.		
. Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nant 2	23c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown	2 - Fetal de	eath 3 🗌	Ectopic pr Other (spe		(23	d. Date of de Month	elivery Day Year	
Is, P.O.	requires that to been signed be should be deta		Part II. Other significant	conditions con	ntributing to death b	ut not resultir	ng in the un	nderlying ca	ause give	en in Part I.				o the cause of death? Probably 4 Donknown	
Records,	The law req	Completed by									24a. Was autop perfo 1 Yes	sy rmed?	prior to death?	utopsy findings available completion of cause of	
of Vital	sician; The certificate irector, pag	Be	25. Was case referred to rexaminer? 1 ☐ Yes 2 ☑ No		Hospital:		/O		Other	ce of Death (Chec	ome 5 Resid		1011 10	 	Ē
n of V	ding Phys h. After this funeral di	cate: To	27. Manner of Death	Pending	28a. Date of injur (Month, Day	ent 2 ER. ry 28. (, Year)	Dutpatient b. Time of injury	$\overline{}$	c. Injury work?	at	28d. Describe h			+WSPAC	1
Division	Hospital or Attending 24 hours after death. Funeral Director: After sted filled in by the fune	l Certificate:		Investigation Could not be determined			, farm, stree			03 2 2 110	28f. Location (S City or Tow		lumber or Ru	ural Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 M	fedical Examin	ician: To the best of oner: On the basis of exe Practioner: To the	xamination an	d/or investig	gation, in m	ny opinior	n, death occurred a	at the time, date a	nd place, ar	nd due to the	cause(s) and manner stated.	-
		-	29b. Signature and title of	f certifier	uler	M	>	29c.	License	number 3 \(\frac{3}{9} \)	8	29d. Date s	signed (Mont	th, Day, Year)	
off	20tiva		30. Name and address of South	person who co	ompleted cause of de	(a) (Type, Pr	int)	WO 2	21157	Flavio	Kn	Her	M.D.	
	stat Registra	C	31. Date filed (Month, Day	y, Year) 2 2 2 20	32. Registra	r's Signature	100	ake	,						1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Sophie Silhen 2010 4:40 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country) New York Days 1 □ M 2 🗓 F Min. 08/25/191 Hours Director 063-07-0329 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits by Funeral Director notified 28a-f 1 Yes 2 X No Rockville Maruland Montgomery 10f. Zip Code 10g. Citizen of What Country? ò must be 23a 20852 U.S.A. 6121 Montrose Road. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces X Yes 2 No 1941ö 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes. Give Specify: 3 Widowed 4 Divorced 1965 Caucasian Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Master Sergeant U.S. Army other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H f item 27 is marked ot r other traumatic even ပ္ Harry Silken Jenny Kalter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Lucy Hassell - Personal Rep. 46 New York Avenue Washington, DC 20001 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 01/05/2011 | Arlington. Virginia 4 Donation 5 Other (Specify) Arlington Natl Cem. Signature of Funeral Service Licenseer
AMEMALLE WARM 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death RON Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Jath Ceru.... Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death cate has been signed by the attendin page 2 should be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🙀 No Month Day Pregnant at time of death g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by BRILLATION 2 X No 3 Probably 4 Unknown Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? this certificate ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural Accident injury 5 Pending 1 🗌 Yes 2 🗌 No Investigation М 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ P^{M} <u>Shweky</u> ecember 2010 Morris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital

5. Social Security Number 6. Sex <u>Bethesda</u> 8. Date of Birth (Month, Day, Year) 06/12/1919 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday If Under 24 Hrs. **Funeral** Hours Min. 1 ፟M M 2 □ F Yrs Director New York 086-01-0658 91 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1X Yes 2 □ No Bethesda Montgomery 10f. Zip Code 10g. Citizen of What Country? ò 10e. Street and Number Funeral items 23a 7012 Loch Lomond Dr 20817 death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married "natural", or Š 2 NoWWII Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clothing <u>Merchant</u> Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental H ဂ္ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Bahira Sabbagh Aboud Shweky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pauline Shweky / Wife 7012 Loch Lomond Dr. Bethesda. MD 20817 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Grdn !12/22/2010 Falls Chirch, VA David Mem. 21. Signature of Funeral Service Licenses Edward Sagel Funeral Direction Inc. 1091 Rockville Pike Rockville, MD 20852 **Blake** Kurt 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Days Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Days <u>Acute Renal Failure</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): al all Cause (Disease or linjury that initiated events resulting in death) Last Days Peritonitis Due to (or as a consequence of): burial-Physician/Medical The law requires that the death certificate be 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 5 Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗓 No 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) of 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 X Natural 5 Pending Division 2 🗌 No 24 hours after death. Funeral Director: A Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed To the Ivithin 2 29c. License number **565123** 29d. Date signed (Month, Day, Year) 12/20/20/0 29b. Signature and title of certif MASERINI

Registrar

State

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8600 Old Georgetown Rd Bthesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Amirali Nader M.D.
31. Date filed (Month, Day, Year)

JAN 04 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 28, 2010 5:53 December Sharon Beth Sharp a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital <u>Rockville</u> <u>Montgomery</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 2/23/1952 1 □ M 2 🕱 F **Director** Washington. 218-56-5816 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland 10a. State Director tx☐ Yes 2 ☐ No Maryland Germantown Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20874-1987 USA 19016 Leatherbark Drive Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2X Married ☐ Yes 2 No þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Broker Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic any injury or other traumatic anse. Harry Isard Constance Sorroka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19016 Leatherbark Drive Germantown, Maryland 20874-1987 John Richard "Rick" Sharp/husb. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
King David
Memorial Gardens 1 🔀 Burial 2 🗆 Cremation 3 😾 Removal from State 4 Denation 5 Other (Specify) 12/31/2010 Falls Church, Virginia 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 Rockville Pike, Rockville, Maryland 20852 21. Signature of Funeral Service Licensee MO1255 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Primary tonea Physician/ cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) e attending physician and do for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant a Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

1 Yes 2 No After this certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) B Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ၉ 1 Malignation 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 \square Pending Matural Natural Accident Investigation within 24 hours after death To the Funeral Director: / completed filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one and title of certifier 29b. Signat 29d. Date signed (Month, Day, Year) 67258 December 30,2010

State Registrar Nicholas
31. Date filed (Month, Day,

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BETH

SHAKON

Medical Center Drive #300 Rochville, Mariland 20850

and address of person who completed cause of death (Item 23a) (Type, Print)

MD 9707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death December 12, 2010 Lilian Bernadette Samuels Medical 12:45pM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4601 22nd Avenue Mt. Rainier Prince George's 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 1 M 2 X F Director Months Days Country) Guyana Hours 126-58-3822 83 0171671927 Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Mt. Rainier 1 Tes 2 No 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 4601 22nd Avenue 20712 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes, Give Year or Dates. Completed 3 Widowed 4 X Divorced 1 Yes 2 No Bi-Racial 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Medicine Aide injury or other traumatic event, Be Nursing Home 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other trainmetic and Mental F is marked o 18. Mother's Name (First, Middle, Maiden Surname, Lackland McKinnon Adelaide Prince 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Gladwin Samuels, Jr. - Son 2900 St. Regis Way, Bowie, Maryland 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 12/18/2010 | Silver Spring, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) erval Between iset and Death Physician/ Onset and J Cervical Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Ectopic pregnancy Pregnant at time of death 5 Other (specify) Day Year g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 🗌 Yes 2 🗶 No 3 🗀 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospita ဂ္ 2 X No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 1 X Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending s after death. I Director: A work? ☐ Accident Investigation 6 Could not be 2 No Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) sompleted filled in by 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, within 24 hours a City or Town, State) Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) Lysel D0023600 January 03, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Bruce Kressel, M.D.

JAN 04 2011

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

5530 Wisconsin Avenue, Suite 1125, Chevy Chase, MD 20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 27, 2010 1:20 p M John Sturey Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Montgomery Silver Spring 12608 Epping Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral (Month, Day, Y 1 🗷 M 2 🗆 F Months Days Hours Min. Yrs 1927 83 Oct. Director 193-24-6465 Usual Residence of Decedent an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD Montgomery Silver Spring 1 Yes 2 No ā 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 20906 12608 Epping Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married X Yes Yes, Give 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3√ Widowed 4 □ Divorced Year or Dates.1946-53 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Engineman Railway other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ൧ Fannie Zazulac Anthony Sturey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4140 Pinewood Terrace, Chesapeake Beach, MD 20732 1 and 2 s of Health Susan Pape/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemeter, crematory or other place Forest Lawn Memorial Park ō Jan. 1 🔀 Burial 2 🗌 Cremation 3 🖳 Removal from State Department of Important: If any injury or Conemaugh, PA 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spr. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Sudden Cardiac Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 5 yrs Coronary Vascular Disease Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and Hypertensive Heart Disease 10 yrs Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ing physician as the burial burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No for Pregnant at time of death ned by the a g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 41 Unknown should Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autonsy death? certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be examiner? Hospital Other: 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural Natural work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined building, etc. (Specify) City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of xamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Certifying Nurse Practioner: To be best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature

State Registrar

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and address of person who completed cause of death (Item 23a) (Type, Print)

Richard Pollen, MD

29

31. Date filed (Month, Day, Year)

10400 Connecticut Ave., #606, Kensington, MD 20895

28-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2/26/2010 7:50P Harold Martin Silver Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bethesda Suburban Hospital Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 1**X** M 2 □ F Months Days Hours Min. **Director** 118 28 6296 1/15/192 New Usual Residence of Decedent an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 XYes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8029 Herb Farm Drive 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc 1X Yes 2 No 1944-If Yes, Give Year or Dates. 1946 ρ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced Completed 1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the Own Practice Physician traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel Silver Esther Lesser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Angelina Silver/Spouse 8029 Herb Farm Drive Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) National Crematory 12/29/2010 | Falls Church, VA 21. Signature of unerah Service 22. Name and Address of Facility Joseph Gawler's Sons, Inc. gous May 5130 Wisconsin Ave., NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List one one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiorespiratory Arrest Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Septic Shock Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Pneumonia Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) as the burial Physician/Medical AROLD SILVER / March Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ þ in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death detached g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign I be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 XNo 1 Npatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 5 Pending 1 🗌 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) P 12/27/2010 D70241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Shanthi Nadar MD

32 Registrar's Signature

8600 Old Georgetown Rd. Bethesda, MD

20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month December 24, Physician/ 2010 2:00 p Serensits, Sr. Stephen Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Renaissance Gardens at Riderwood Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Iov. 3, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **№**M 2 □ F Months Days Hours Director 198-10-2629 89 Vov. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 🗆 Yes 2 🏝 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA 3118 Gracefield Road, #514 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White Completed 3 Divorced 4 Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Start-up Supervisor DC Metro Authority Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 August Serensits Anna Malits permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Ccde) 696 Ocean Ridge Parkway, Ocean Isle Beach, NC 28469 Joseph S. Serensits, Jr./Son injury or other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 x Burial 2 Cremation 3 Removal from State 30, Dec Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, MD Name and Address of Facility
rancis J. Collins Funeral Home Inc.
20 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Cell Carcinoma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has page 2 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 🗌 Yes 2 🖪 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 X Natural 5 \square Pending work? 1 Yes 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director. A Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10+1 44156 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

3110

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland State of Maryland		artment of H			giene	010	43100	
	₩ Dh	/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath		3. Time of Death	
N. A.	Physicia Medi		Fujio Sekiya				Decembe	er 23,	20^{Year}_{10}	3:20A M	
	Exami	ner	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or		'n		inty of Death		
die			11317 Gainsbough Road 5. Social Security Number 6. Sex 17. Age (in vrs. last)		Potom				ntgomer		
	Funeral Director		5. Social Security Number 218-45-6803 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Day April]	, Year) 1964	9. Birthpl Countr Japa	ace (State or Foreign y) n	
	and show	ě	10a. State 10b. County 10c. City,	Town or Loc	cation				10	d. Inside City Limits	
	Mary 28a-f otifie	Funeral Director	Maryland Montgomery Po	tomac						1 Kes 2 No	
	h the kaor: ben	무	10e. Street and Number		10f. Zip Code	-		10g. Citizen	of What Count	ry?	
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900	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f show ce event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.		Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🛣 No		pecify Yes or No- p Rican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specify: Asian			
5-	2 hou "nat edica	ple	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa	tion	king	16b. Kind of	f Business Indu		
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an	12 should be file alth and Mental H 27 is marked or r traumatic evel	ပ	Takuo Sekiya				ne <i>(First, Middl</i> e, <i>I</i> Tajima	Maiden Surna	ıme)		
ary	hould and IV s ma umat		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street ar			City or Town	State Zin Co	uda)	
Σ	id 2 salth salth an 27 i		Keiko Sekiya - Spouse		7 Gainsbo					ide)	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be files Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic ever <u>once.</u>		1 ☐ Burial 2 tv Cremation 3 ☐ Removal from State	netery, crem	ition (Name of atory or other place 1n Cremat		Date /31 /2010		n - City or Tow	n, State Maryland	
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	Medical Examiner the purial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
). Box 68760	or attending Physician: The law requires that the death certificate be executed faire death. Birector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unkn	eath 3 🗌	Ectopic pregnancy Other (specify)				Date of delivery Month D	ay Year	
P.O.	that the ned be deta	by P	Part II. Other significant conditions contributing to death but not resulting	ng in the un	derlying cause give	n in Part I.	23e. Did tob	acco use cor	ntribute to the	cause of death?	
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₹ ;	Physic this ce al direc	2	1 ☐ Yes 2 🔏 No Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient	Other		me 5 🔀 Reside	nce 6 🗆 Ot	her (Specify)		
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Division of Vital	after Direc	S	4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	t, factory, office		28f. Location (Str. City or Town,		ber or Rural Ro	oute Number,	
	Hospital of 24 hours a Funeral D	cal	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Charles 2 Medical Experience 2 that the best of my knowledge 2 Medical Experience 2 that the best of my knowledge 3 that t	ie death oc	Cured at the time d	ato and place, or	d due to the sour	0(-)			
-	lo the Hospital of Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	only one) 3 Certifying Nurse Practioner: To the best of my kn	d/or investig	ation, in my opinion	death occurred at	the time date and	halace and di	up to the course	(s) and manner stated. d.	
			29b. Signature and title of certifier)	29c. License n		29		ed (Month, Day		
	12	-	20 Name and address of a		D4308	<u>ی</u>			cember	27, 2010	
		[30. Name and address of person who completed cause of death (Item 23			0		1	1 1 2		
	State	9	George Aristides Sotos, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature	9/0/	Medical	center L	rive, Ro	ockv11.	re MD 2	.0850	
	Registra		DEC 29 2010 Beaux B.	19 1000	All facility						

10-09656

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Audrey C. Sentman	1- For State Continuity and 7 Depart	ment of Health and Mental Hy	ygiene					
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		Reg. No. 2. Date of Death 3. Time of Death					
Medical Examiner	AUDREY CAROL SENTMA	AN	Month Day Year December 15, 2010 0825 hrs					
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death					
	Dorchester General Hospital	Cambridge	Dorchester					
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last							
Director	173-64-1914 1 M 2XF 27	Yrs. Months Days Hours Min.	NOV 03, 1983 PERKASIE, PA					
	Usual Residence of Decedent		TERRASIE, FA					
Maryland 28a-f show any d at once.	10a. State 10b. County 10c, City, To	wn or Location	10d. Inside City Limits					
and sho	DELAWARE SUSSEX COUNTY GEORG	ETOWN, DE	1 Yes 2 X No					
the Maryland a or 28a-f sh tified at onco	10e. Street and Number	10g. Citizen of What Country?						
D 21215-0036 Should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f sho atic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	26961 WIDEN WAY	19947	UNITED STATES					
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21215-00; ould be filed with the Mental Hygiene a marked other it tic event, the Mec	JOHN S . SENTMAN 19a. Informant's Name/Relationship (Type, Print)	CAROL	A. FISCHER					
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e, MI and 2: Health 2: Health 27: r traum		e of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State					
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Baltimore, permit. Pages I am Department of Heal Important: If item injury or other tra		STATE CREM.CTR. JAN	02,2011 MILLSBORO, DE					
Bal Dermi Impo	21. Signature of Euneral Service Licensee MO 136	22. Name and Address of Facility	19966					
	23a. Part I. Enter the disease, or complications that caused the death. Do		E PO BOX 125 MILLSBORO, DE					
Physician /Medical	failure. List only one cause on each line.		respiratory arrest, shock, or heart Approximate Interval Between Onset and					
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D. Box 68760 the death certificate by the attending physiched for use as the butter of the street of	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant 1 Live birth		23d. Date of delivery					
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that the detached detached	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?					
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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.								
Med Con	and manner stated. 29b. Signature and title of certifier	29c. License number						
		OCME	29d. Date signed (Month, Day, Year)					
	Theoder M. King JR., M	O.C.WI.E.	December 16, 2010					
	 Name and address of person who completed cause of death (Item 23a Theodore M. King, Jr., MD. Assistant Medical Example. 		MD 24204					
Circ		miner 111 Penn Street, Baltimore	, MID 21201					
State Registrar	31. Date filed (Month, Day Jehr) 2 4 20 22. Registrar's Signature	A backer						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DECEMBER THOMPSON RUDOLPH R. 26 2010 6:42 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DORCHESTER GENERAL HOSPITAL CAMBRIDGE DORCHESTER If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 □ F Months Hours Min. (Month, Day, Year) SEPT 13 Director MARYLAND 578-40-7903 81 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD MONTGOMERY SILVER SPRING 9 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 10110 NEW HAMPSHIRE AVENUE #201 20903 items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black. White, etc. 1 Never Married 2 Married "natural", or þ 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant; If item 27 is marked other tha ury or other traumatic event, the N College (1-4 or 5+) 12TH CARPENTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ FRANK THOMPSON GLADYS MILES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRUCE LYNN/SON 1808 ST. GEORGE WAY MITCHELLVILLE, MARYLAND 20721 Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GATE OF HEAVEN CEME. 1/6/2011 4 Donation 5 Other (Specify) SILVER SPRING, MD Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ DIABETES disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PACEMAKER FOR COMPLETE HEART BLOCK Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil HYPERTENSION that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 1 Yes 2 L 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No certificate I 1
Yes 2X□ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 TyNo မ Other: 1 Inpatient 2 X ER/Outpatient 3 I DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural injury work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The district of the cause of th (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Allas. D45296 DECEMBER 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 CONNECTICUT AVENUE KENSINGTON, MARYLAND 20895 SHAMIMA ABBAS M.D. 31. Date filed (Month, Day, Year) State 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 12/30/2010 MARY ELIZABETH ORMOND VINES 3:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TEMPLE HILLS PRINCE GEORGE'S 4613 ALCON DRIVE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Min 1 M 2 T F Hours 7/28/1925 Hookerton Director Yrs. 238-40-6555 Usual Residence of Decedent ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Maryland Prince George's Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15202 Derbyshire Way 20607 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ō þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: "natural" Completed 3 X Widowed 4 □ Divorced **Black** Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cosmetologist e 1 and 2 should be filed with of Health and Mental Hygie If item 27 is marked other in other traumatic event, th Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Windsor Ormond Mary Lee Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha A. Vines / Daughter 15202 Derbyshire Way Accokeek, Maryland 20607 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans 1/13/2011 Cheltenham, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee *keo* 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Interval Between Onset and Death YEAR Immediate Cause (Final Physician/ disease or condition resulting in death) METASTATIC RENAL CELL CARCINOMA Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a nonnequence off: Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician dbe detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed HYPERTENSION, CARDIOVASCULAR DISEASE, RENAL FAILURE 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No CONGESTIVE HEART FAILURE, TYPE II DIABETES MELLITUS 24a. Was an this certificate has autopsy performed? Yes 2 V No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital ပ္ 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) n 24 hours after death.

e Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) Umarsha MD D 07660 1/6/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6525 Belcrest Road Suite 130 Lewis W. Marshall Hyattsville, Maryland

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 1 2011

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#23a. PrtIIPerPhys. PC1-11-11cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month рМ Ollie A. Vass 12 28 2010 1:30 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9402 Concord Road Upper Marlboro Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Year) 1 □ M 2 🕅 F Months Hours Yrs Director 403-34-0982 89 02 08 1921 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event. It e Medical Expenient must be a difficed at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XYes 2 □ No Prince Georges MD Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? Funeral 9402 Concord Road 20772 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐Yes 2 No þ 3 Widowed 4 □ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Private 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) David Lillard ပ Cora Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Allen / Goddaughter 9402 Concord Road Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 1/4/2011 Brentwood, MD 21. Sign tur un ral Servi I insee 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, ruch as ardiac or a piratory arrest, shock, or heart failure. List only one cause on expline. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the at be detached f 1 ☐ Yes Part II/Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş icate has been sig page 2 should b Completed 1 □ Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe Yes 2 1 □Yes 1 ☐ Yes 2 ☐ No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No 27. Manner of Death Hospital: Other: Certification: To this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) After 1 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred atural 5 Pending n 24 hours after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the within 2

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title!

DHMH 17 Rev 1/2001

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date sinned (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene?

			For State Registrar	State	of Marylar		artment o tificate o			Mental Hy	giene	010	43107
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	Examili	iei	Holy Cross Hos		,		Silve				Mon		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗶 F	7. Age (In yrs.		If Under 1 Ye Months Day			8. Date of Bir	rth ay, Year)	g. Bir	thplace (State or Foreign ountry)
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DIVISION OF tal or Attending Plus after death.	To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tree.		4 Homicide determ	inad 28e. Place	e of Injury - At he ling, etc. (Specif		et, factory, offic	e		28f. Location (S City or Tov		mber or Ru	ral Route Number,
ospita hours	uneral	Medical	29a. Certifier 1 Certifying	Physician: To the	best of my know	ledge, death o	ccured at the tir	ne, date a	and place, ar	nd due to the ca	use(s) and m	anner as sta	ated.
the H	the Fi		only one) 3 Certifying	Nurse Practioner:	isis of examination: To the best of m	n and/or investi ny knowledge, d	eath occurred at	the time,	date and pla	et the time, date a ce, and due to th	e cause(s) and	manner as	
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, ,			30. Name and address of person v	who completed cau	se of death (Item	n 23a) (Type Pi	rint)	<u>U</u>	~7	2/	46(21	1301	1,21,2010
			Theodore Igweb		Box 36			ırg,	Mary1	and 208	85		
	Stat		31. Date filed (Month, Day, Year)		Registrar's Signa		A)						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Dec. Physician/ Williams Ferro1 25 1400 p ^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Oct. 22 Days Hours Min. 1 🖾 M 2 🗶 F **Director** 580-09-9662 59 Yrs. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director Md. Montgomery Germantown 1X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral or items 23a 12913 Falling Water Circle 20874 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. arked other than Elementary/Seconday (0-12) 12th Public School College (1-4 or 5+) Teacher Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Marilyn Tutein ည Burnette Williams be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 19917 Buhrstone Drive Gaithersburg, Md. 20886 Jamila Michael (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12/31/2010 Chesapeake Crematory Beltsville, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
W. H. Bacon Funeral Home, Inc.
3447 14th Street, N.W. Washington, DC 20010 Sonature of Funeral Service Linensee 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Intracranial Hemorrhage disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate e as the burial-transit executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown ρď Dav Year the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| page 2 should be Prior Stroke the Hospital or Attending Physician: The law requires in 24 hours after death.

the Funeral Director: After this certificate has been sign Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2X No 1 Yes 2 XNo 25. Was case referred to medical Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🙀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ျ Division of 1 Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? X Natural injury 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contributed Nurses Practioners To the constraint of the c 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) D37891 Dec. 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Rajuanesh, M.D. 121 Congressional Ln. #409 Rockville, Md. 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature backs. ZUI Registrar 04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 24 Physician/ Mae Weiss 10:20p M December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ring House Rockville Montgomery 5. Social Security Numbe 8. Date of Birth
(Month, Day, Year)
JULY 05, 1911 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 X F Months Days Hours Massachusetts Director 059-05-1112 Yrs 99 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Me It al Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 Yes 2 No Maruland Montaomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1801 Jefferson Street, Apt. #402 20852 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black. White, etc. þ 1 Never Married 2 Married Yes 2 X No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ္ရ Jacob Zeldes Fanny Leschinsky permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David L. Weiss - Son 14524 Antigone Drive, N. Potomac, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Hebron Cemetery 12/29/2010 Queens. New York 21. Signature of Funeral Service Licer(see) 10 # 1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. |11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear the ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Renal Failure disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Critical Aorta Stenosis Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to fur as a consequence of that the death certificate be executed <u>Coronary Artery</u> Disease that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 X No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hypertension 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an autopsy performed? Yes 2 1 No 2 No 1 Yes Hospital or Attending Physician: 7 24 hours after death. Funeral Director: Atter this certifice Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital 2 🔀 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide (Month, Day, Year) 5 Pending work?
1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npleted filled in by 4 Homicide determined Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 501/0 W D0057884 December 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Damien Doyle,

31. Date filed (Month, Day, Year)

M.D.

Wasserman Bldg., Rockville, MD 20852

6121 Montrose Road.

Registrar's Signat

				State of Man							Legible	
			for State Registrar	State of Mar		•	te of Death			Reg. No.	010	43110
	Physicia		1. Decedent's Name (First, Middle, Last) WINIFRED				JONE		2. Date of Dear	th Day	, 2010	3. Time of Death
3.	Medic Examin		4a. Facility Name (if not institution, give str			4b. Cit	y, Town, or Locatio	on of Death		4c. 0	County of Dea	th
- "	, 		MONTGOMERY 5. Social Security Number 6. Sex	HENERA			O L N er 1 Year If Uno	der 24 Hrs.	8. Date of Birth			TOMERY
	Funeral Director			M 2 X F	yrs. last birtho	Months			(Month, Pay,		9. Bir	thplace (State or Foreign ountry) New York
	aryland a-f show fied at	Funeral Director	10a. State 10b. County Maryland Montgon		c. City, Town o	or Location	Sandy	Sprin	ıa.			10d. Inside City Limits 1 Yes 2 No
	the Mi or 28	Dir	10e. Street and Number	letg		10f. Z	ip Code	0,000		109. Citiz	en of What Co	
	h with	nera	17340 Quaker Land				208					.S.A.
36	is filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 💆 Divorced	 Was Decedent Ever Armed Forces? □ Yes 2 X No If Yes, Give Year or Dates. 	in U.S.		edent of Hispanic e ecify Cuban, Mexic 2 🛛 No Spec		ecity Yes or No- Rican, etc.)		4. Race - Ame Black, Whit pecify:	
2-0	2 hours "natur dical J	plete	15. Decedent's Educ (Specify only highest grade	ation	16a. D	ecedent's Us	ual Occupation ork done during m	ost of work	ina	16b. Kin	d of Business	Industry
121	ithin 73 ene. • than he Me	Com	Elementary/Seconday (0-12)	College (1-4 or 5+)	ìñ	fe. DO NOT u	se retired) 2ge Profe				Educ	cation
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ylar	should be file h and Mental I 7 is marked o traumatic eve	ပ	Unascertainable_						tainable			
Maryland 21215-0036			19a. Informant's Name/Relationship (Type Kasey Jones – Daug			0	ss (Street and Nun Idikan Av					p Code) and 21206
Ē,	t of Health If item 27 or other tra		20a. Method of Disposition		20b. Place of D		ame of		Date		ation - City or	
Baltimore,	t. Page 1 tment of it tant: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			coln C	rematory					Maryland
Fas	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	MO1844	/	11800	New Hamp	shire	Ave., S	Silve		l Home, Inc. ing, MD 20904
	Physician/		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the cause on each line.	death. Do not	enter the mo	de of dying, such	as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death 12 hvs
أتحمد	Medical Examiner		resulting in death)	Due to (or as a co								48hrs
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of)							10113
	cuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	Durate (en en en								
0	be executed sician and burial-transit	cal E	resulting in death) Last	Due to (or as a co	nsequence of)							
376(ificate ig phys as the		IF FEMALE:			_						
Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. the Funeral Director. After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tin 9 Unknown	Fetal death	3 Ectopic 5 Other				23	3d. Date of de Month	livery Day Year
P.O.	s that the gned by be detacl	2	Part II. Other significant conditions control SEPTIC SHOC	-	ot resulting in	the underlying	cause given in Pa	art I.				o the cause of death?
rds	require been s should	eted	_ GET THE DITCE						24a. Was a			Itopsy findings available
Seco	he law ite has l	Completed							autops perfori	sy	prior to death?	completion of cause of
tal	cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?	spital:			26. Place of D	eath (Check				
Division of Vital Records, P.O.	ing Physi (fter this c uneral dir	ate: To	1 ☐ Yes 2 🗹 No Proceed to 1 ☐ Yes 2 🗹 No Proceed to 1 ☑ Natural 5 ☐ Pending	1 Inpatient 28a. Date of injury (Month, Day, Ye	28b. Tin	ne of iry	28c. Injury at work?		ome 5 Reside 28d. Describe ho			sify)
visior	or Attend ter death irector: A n by the f	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S		M , street, facto	1 Yes 2 ry, office		28f. Location (St. City or Town		Number or Ru	ral Route Number,
Ö	ospital o	Medical C	29a. Certifier 1 Certifying Physici									
	the Ho hin 24 the Fu mplete	Med	only one) 3 Certifying Nurse F	On the basis of exam	ination and/or in tof my knowled	ige, death occ	urred at the time, d	late and plac	e, and due to the	cause(s)	and manner as	
	2 1 2 8		29b. Signature and title of certifler	curin	7,41		oc. License numbe				signed (Monti	
	1"		30. Name and address of person who com	pleted cause of death	ı (Item 23a) (Ty	pe, Print)			10	J-00	- A 4 +	R 27, 2010
			OLUYEMISI 31. Date filed (Month, Day, Year)	ADEWUI			MONT	GD ME	RY CT	モルヒ	KAL	HOSPITAL
	Stat Registra	_	DEC 29 2010	32. Registrar's	Signature 1	200000	·					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ YOUNG CHARLES BRIGHAM 1228 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hours COCUMBEA - BD COVER BURRAGE HOSPIME 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) June 10, 1950 Country District of Columbia 1 X M 2 🗆 F 60 Director 214-52-6054 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 No Upper Marlboro Prince Georges Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 10133 Prince Place Unit # 404 "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) HVAC Owner 12 4 is marked other t. Page 1 and 2 should be filed wi trment of Health and Mental Hygin trant; If item 27 is marked other njury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Evelyn Gross Joseph Stanley Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10133 Prince Place Apt. 404 Upper Marlboro, Maryland 20774 Valerie Anastasia Young/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth once. 1 X Burial 2 Cremation 3 Removal from State January 8, Charles Memorial Gardens 4 Donation 5 Other (Specify) 2011 Leonardtown, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, Maryland 20650 23a. Part 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BYSRYTHMIA Physician/ VENTILLCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DISEASE. vertores Sequentially list on dilione if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner CAMBIO -transit Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last the burialattending physician DISEASE Physician/Medical Records, P.O. Box 68760 as t IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Vear Pregnant at time of death g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? 1 Yes 2 No performe this certificate 1 ☐ Yes 2 ☐ No Division of Vital Be (25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A50538 30 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYAN 55 Cedar Lane COLV

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

M(wellch

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 12 2010 Cleda Lavine Zepp 11:56 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll Hospital Center Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 25€ Months Days Hours Min. 87 235-38-4049 Yrs **Director** WV Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City. Town or Location 10d. Inside City Limits the Maryland Director notified 1 Tes 2 Ves 2 Carroll Westminster MD 5 10e. Street and Numbe. 10f. Zip Code 10g. Citizen of What Country? must be 23a 418 Pinch Valley Road 21158 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 100 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black. White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. Specify: White "natural" Completed 3 X Vidowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the C&P Telephone telephone operator traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Beulah Virgie Blizzard Willie Jasper Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important: If item 27 is a any injury or other traumonce. Neal Sisler/son 1418 Pinch Valley Road, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Carroll Cremation, Inc. 12/28/2010 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA Kalux 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir physician and the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death been signed by the should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Liberrown Completed 24b. Were autopsy findings available 24a. Was an has autons prior to completion of cause of page Hospital or Attending Physician: The certificate 2 IN Yes 2 🚺 1 Yes 25. Was case referred to medical 26, Place of Death (Check only one) Be examiner's Hospital 2 1 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 I this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and ti

State Registrar

vA2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Keinera

Registrar's Signature

Gernay

Day, Year,

DEC 28

31. Date filed (Month,

Malcalmolne, Westmany MJ 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sylvia Lenoff Zeidner 2:00a M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens - Riderwood Silver Spring Prince George's Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York **Funeral** 8. Date of Birth 1 🗆 M 2 🕱 F Months Hours Min June Director 83 578-38-3020 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at Director 10d. Inside City Limits Maryland Prince George's Silver Spring 1 Yes 2 X No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3156 Gracefield Road. 20904 U.S.A items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces "natural", or Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give 3 Divorced Specify. White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joe Lenoff Hilda Gittleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Philip M. Zeidner - Spouse #306, Silver Spring, MD 20904 3156 Gracefield Road. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Mem. Grdns. 12/28/2010 Olney, Maryland 21. Si nature of Funeral Se vice/Licen ee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00709 res <u>11800 New Hampshire Ave.. Silver Spring. MD 20904</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1mmediate Cause (Final Onset and Death Physician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine If any hading to in medicause. Enter Underlying Dua to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last signed by the attending physician and be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cor Pulmonale Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown Osteoporosis 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending 2 🗌 No Investigation 6 Could not be Accident the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 28f. Location (Street and Number or Rural Route Number, within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Siar ture and title of certifier 2 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 29, 2010 3:00 Ам Leora Elizabeth Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Egle Nursing & Rehab Center Lonaconing Allegany 6. Sex 1 M 2 X F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day,
Dec. 9, 5 Social Security Number 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** Days ^{Ye}1921 Hours Mary Tand 89 Yrs. Director 218-16-3981 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No or 28a-1 Lonaconing MD Garrett 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral USA 21539 7352 Avilton-Lonaconing Rd. or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give "natural", 3 X Widowed 4 ☐ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. **7 is marked other than "**n Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပ Annie Winner Olen McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15187 Old Beachwood Rd., SW, Lonaconing, MD 21539 1 and 2 s if Health a item 27 i Gladys Wilhelm/Niece injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Jan. 1, 2011 Avilton, MD 4 ☐ Donation 5 ☐ Other (Specify) Ann Cemetery 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Lie eumai Box 275, Grantsville, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ALZIHEIMERS Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ò Month Day the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. signed I 23e. Did tobacco use contribute to the cause of death? ģ CONGESTIVE HEALT FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown has been signed 2 Completed ACTEMEN DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No PERIPHENAL 24a. Was an autopsy performed? Yes 2 page certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 100 1 Yes To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 Yes 2 No injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day Year) Strelle A-269-7- 12-29-2010 126507 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit Sidhu, 925 Bishop Walsh Rd., Cumberland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

68760

Box (

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland / Dep	artment of Healtr rtificate of Death		tal Hygien Reg. N	0010	1.2115
	Physicia	m/	1. Decedent's Name (First, Middle, Last)			2. [Date of Death	T- W-+	3. Time of Death
<i>A</i> .	Medic Examir	cal	Sharon 4a. Facility Name (if not institution, give st.	Beverly	4b. City, Town, or Location			6, 2010 c. County of Death	1600 M
	LXaiiii	iei	2559 West Lafayet		Baltimore	e		c. Ocumy of Death	
	Funeral Director		212 00 00 10	M 2 D F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 1 Months Days Hours	er 24 Hrs. 8. 0	Date of Birth Month, Day Year COT 2	9. Birt Cou	hplace (State or Foreign intry)
	yland f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			•		10d. Inside City Limits
	the Mar or 28a- e notifi	Director	10e. Street and Number	BACTIM	10f. Zip Code		10g. C	itizen of What Co	1 Yes 2 No
	th with the ms 23a must be	Funeral	2559 W. LAF	·	21214			USA	
920	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at.	\$	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic I ☐ Yes 2 No Specif	an, Puerto Rican	es or No- , etc.)	14. Race - Amer Black, White Specify: BL	
15-0	72 hou n "natu Aedical	Completed	15. Decedent's Edu (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during mo O NOT use retired)	ost of working	16b.	Kind of Business !	ndustry
212	iled within I Hygiene. other tha		Elementary/Seconday (0-12)	College (1-4 or 5+)	ERICAL		1+2	OSPITA	<u> </u>
land	e d ta	To Be	17. Father's Name (First, Middle, Last) £LMER MODI	ee		ther's Name (Firs	t, Middle, Maider		
Baltimore, Maryland 21215-0036	2 she than 27 is trau		19a. Informant's Name/Relationship (Type	Print) 19b. Mailir	ng Address (Street and Num.	ber or Rural Roy	te Number, City of	r Town, State, Zip	Code) 2/229
more,	Page 1 and 3 nent of Heall ant: If item 2 ary or other		20a. Method of Disposition 1	20b. Place of Dispo cemetery, crem	natory or other place)	Date	2011 50	ocation - City or	26 MO
Baltir	permit. Page 1 a Department of H Important: If ite any injury or otl		21 Signature of Funeral Service Licenses	Ellis 22	Name and Address of Factor	ility GARY	L.RO	ILINS I	21705
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not enter					Approximate Interval Between
*	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	A.S.C.V.D. Due to (or as a consequence of):					Onset and Death
	Examiner	jr.	Sequentially list conditions, b.						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	Due to (or as a consequence of):					
_	icate be executed I physician and s the burial-transit	cal Ex	resulting in death) Last	Due to (or as a consequence of):					
8760	rificate ng phys as the	Medical	IF FEMALE:				i		
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown		Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
P.O	es that thisigned by	by	Part II. Other significant conditions control Stomach Cancer	ibuting to death but not resulting in the u	nderlying cause given in Par	rt I. 2			the cause of death?
ords	v requir s been s should	Completed	o comacii canoci			2	24a. Was an	24b. Were auto	opsy findings available
Rec	ysician: The law is certificate has director, page 2	Com					autopsy performed? 1 □ Yes 2 🛣 N	death?	ompletion of cause of 2 No
/ita	sician certifi irector	To Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	spital:	Othor	eath (Check only		· 12] ou	Coope
Division of Vital Records, P.O.	I or Attending Phy after death. Director: After this I in by the funeral d	Certificate: To	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation	1 Inpatient 2 ER/Outpatien 28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 Yes 2	28d. D	escribe how inju	6 🔀 Other (Specif ry occurred	y) Scene
Divisio	al or Atte s after de il Directo ed in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office		ocation (Street ar ity or Town, State	nd Number or Rura s)	al Route Number,
_	ne Hospit n 24 hour ne Funera pleted fill	Medical	(Check 2 X Medical Examiner	an: To the best of my knowledge, death one of the basis of examination and/or invest the death of the basis of examination and/or invest the best of my knowledge, death of the basis of my knowledge, death of the basis of my knowledge, death of the basis of the basi	igation, in my opinion, death o	occurred at the tir	ne, date and place	e, and due to the ca	ause(s) and manner stated.
	To the within com		29b. Signature and title of certifier	MD DMF	29c. License number D37197	7		ite signed (Month,	
	11	1	30. Name and address of person who com				. 1	1 1 0	704 (501
	ტ∖ [≬] Stat	_	31. Date filed (Month, Day, Year)	D, DME, 15 West Sev 32. Registrar's Signature	enth Street,	freder:	ıck, Mar	yland 21	/01-4501
	Registra	r	JAN 20 2011 Den	MAN M. Manney					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 20T0 3:25 A M Albert Bailey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Fayette Health & rehab 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗆 F Months Days Hours Min (Month, Day, Year) ne 15, 1944 North Carolina **Director** June 244-76-1480 66 Usual Residence of Decedent 28a-f show 10a. State 10h County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA items 23a 21215 1505 W. Baltimore Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2X No Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel 1aborer unk unk other traumatic event, Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Sharon Floyd - legal guardian 300 Metro Plaza; Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of P Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 █ Other (Specify) In State 22. Name and Address of Facility State Anatomy Board Signatur of Euneral Service Licerum 16 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Part or heart failure. List only one cause on each line Immediate Cause (Final DEMENTA Physician, disease or con Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami nouna Cause (Disease or linjury that initiated events resulting in death) Last bunial-trans and Due to (or as a consequence of): attending physician for use as the buna Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ To in the past 12 months? Month Day Year signed by the a d be detached f 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? After this certificate I 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2. No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No injury Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 451CIANIN 120064532 01 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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32. Registrar's Sig

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 27, **Physician** 2010 11:11 AMM December Leonard Douglas Ball /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1101 Druid Hill Avenue #1313 Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec 29, 1944 9. Birthplace (State or Foreign 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F Mary Land Director 65 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Tayes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Lahould be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or the many on other traumatic mental in the many or other traumatic mental in the many o **HSA** 21217 1101 Druid Hill Ave; Apt 1313 Funeral 12. Was Decedent Ever in U.S.Ink | 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? Race - American Indian, Black, White, etc. Armed Forces? 1 □ Never Married 2 □ Married black If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viola Ball ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Truesdale - nephew 2825 Brighton St; Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☑Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Scicensee 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a c sequence of): Examiner NE MONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a sonsequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy REPLACEMEN 1 □Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 \(\Bigcap \) Nursing Home Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 17/1 Natural 2 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Box 68760. P.0. of Vital Records, the Hospital or Attending Physician: Division

-trar and burialphysician the as for signed by the a page 2 s has certificate director this To the Funeral Director: After the completely filled in by the funeral within 24 hours after death. To the Funeral Director; A

show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at

Baltimore, Maryland 21215-0036

State Registrar

Medical

Kofi Owusu-Antwi

4 Homicide

29b. Signature and title of certifier

29a. Certifier

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) l

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland General Hospital Baltimore, MD

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 25 per me, g911,01/21/2011.dhb. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year JARY S CARROLL 21:28 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** INTUERSITY of MARYLAND MEDICAL BALTIMORE (ENTH 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Md. 8. Date of Birth **Funeral** 1 MM 2 🗆 F Months Days Hours 0191271954 213-64-0424 56 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location death with the Maryland Examiner must be notified at 10d. Inside City Limits Director Md Carroll 1 🗆 Yes 2 🔀 No Woodbine 10g. Citizen of What Country? è 10e. Street and Numbe 10f. Zip Code 23a Funeral USA 5934 Woodbine Rd. 21797 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. and Mental Hygiene. is marked other than "natural", or i ģ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: Specify: White Completed 3 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) County Roads State Govt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic even once. ပ္ Mildred Wilson Jack V. Carroll Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Carroll(Brother) 11500 Frederick Rd. Ellicott City, Md. 21042. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 09/08/2010 Crest Lawn Marriotesville, Md. 21. Signature of Fur Processing Envice License 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1, Enter the disease Immediate Cause (Final disease or condition Onset and Death Physician/ LNTRACRANIAL Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events that the death certificate be executed by the attending physician and tached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Box in the past 12 months? Month Day Year Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached to Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 2 🔀 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?

14 Yes 2 No Division of Vital 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accider iniury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JEPTEMBER 3,2010 address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) BASSMAN 22 GREENE BALTIMORE

State Registrar

4

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 1607 PM **Physician** Davies 12 29 2010 40 Tim /Medical 4a. Facility Name (If not institution, we street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Center Silver Spring mD 9. Birthplace (State or Foreign Country) U.N.K. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Hours Months Days 10M 20 F 59 Yrs. 215-52-5315 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County 28a-f ehow other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Silver Spring Montgomery Director 10g. Citizen of What Country? USA 10f. Zip Code 10e. Street and Number ō 20906 13115 Bluehill Road 238 Pages 1 and 2 should be filed within 72 hours after death nent of Heelth and Mental Hygiene.
ant: If item 27 ie marked other then "naturei", or items 23 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᠫ No If Yes, Give Year or Dates: 11. Marital Status white 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) 1111k Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
401 Hungerford Dr 2nd f1r; Rockville, MD 20850 19a. Informant's Name/Relationship (Type, Print) Donna Klein - legal guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Depertment of H tmportent: if ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation & Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 21. Signature of Suneral Service. Liceasee 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or a consequence of): /Medical Examiner Atrial Febrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sete hes been signed by the attending physiclen and page 2 should be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Diabetes Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Schizophre IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 ☐ Yes 2 ☐ No 2 9 No 1 Yes 25. Was case referred to medical examiner? 26. Place of D. ath (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Universing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ☐ ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner J Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending 1 er atural efter death.

Director: Aft
d in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours el To the Funerel D completely filled i Hospital 1 Centifying Physician: To the best of my kin whole death occurred at the time date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12/30/10 0.0. H6762 30. Name and address of person who completed came of death (Item 23a) (Type, Print) 20906 Silver Bel Pre Ra 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 4 2011

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 26 2010 Physician 1. 00 P N James J. DiGrazia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Potomac Valley Nursing & Wellness Ctr Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 1, 1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 84 579-32-1611 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ehow r then "naturel", or items 23a or 28a-f ehov the Medical Exeminar must be notified at 1 Yes 2 No Completed by Funeral Director Montgomery Bethesda MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4521 East West Highway #607 20814 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Unk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry UNK 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygiel Importent: If item 27 is marked other It any injury or other traumatic event, Ita once. unk unk 18. Mother's Name (First, Middle, Maiden Sumame) $\, unk \,$ 17. Father's Name (First, Middle, Last) unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 W. Middle Ln; Rockville, MD 20850-2214 Monica Harms - attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) in state 21. Signature of Funeral Swice Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2 weeks well More /Medical Due to (or as a consequence of) **Examiner** Par Kinsons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien end s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical signed by the ettending phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 Yes 2 No 1 Tyes Division of Vital : After this certification : 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Medicai Certification; To 27. Manner of Sath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 038262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A IMENIATED TO 2401 Research BLVD Suite 31. Date filed (Month, Day, Year) 82. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

10-10087 Gavino Euseda

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

3. Time of Death

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pamela Fairgrieve Jane Medical 4a. Facility Name (if not institution, give street and number)
WM Regional Medical Center 4b. City, Town, or Location of Death County of Death
Allegany Examiner Cumberland If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 TXF 217-88-3132 49 Maryland Apr. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Allegany MD Barton 1XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19700 Lower Georges Creek Road 21521 Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hospital Elementary/Seconday (0-12) College (1-4 or 5+) Cook 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calvin Kitzmiller ပ Genevieve Skidmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Fairgrieve/husband 19700 Lower Georges Creek Road, Barton MD 21521 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 12/30/2010 Cumberland Maryland Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Marsel 111 Church St, Westernport Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ anoric weeks disease or condition resulting in death) Medical Examiner emouari Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Pregnant at time of death Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mixed connectue tissue disorder 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 2 🗆 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 A Inpatient 2 ER/Outpatient 3 DOA ျပ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my monitorings, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) Drunel 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Huma Shakil, 625 Kent Ave, Cumberland, MD 21502 31. Date filed (Month, DAN - 3 2011 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2010 8:15 December AM Wallace Graham /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long Green Nursing Home Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, April 24, 1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₺ M 2□ F Months 1932 Maryland Director 215-34-9445 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Invalid Exprinter must be notified at appear. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Yes 2 No MD Baltimore 10e. Street and Number Zip Code 10g. Citizen of What Country? USA 21212 115 E. Melrose Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ∐Yes 2 ⊠ No If Yes, Gîve Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) truck driver interstate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Zander McHaughlin ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1224 N. Decker Ave; Baltimore, MD 21203 Ann Culley - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5₺Other (Specify) in State Signature of Euneral Syrvice 22. Name and Address of Facility State Anatomy Board Sicensee Wade Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Pan 1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate disease or condition resulting in death) Chine (Final Physician granced /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Exam & Drovazen attending physician and for use as the burlal-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical WID IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s certificate has b irector, page 2 sł 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐Yes 2. No funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Ye, After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and dr

29b. Signature and title of pertifier

821 N. EUTAW ST Registrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

Zerova S.

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1- For Amend Items Registrar	State of M	aryland/ per	Departi me gr Certifi		28720118 Death	_	_	10 1	3124
			1. Decedent's Name (First, Middle, La						2. Date of De	eath		. Time of Death
	Physici /Medi		Carl Charles Hof	fmaster					Dec	Day	2010 C)847A
	Examir	ner	4a. Facility Name (If not Institution, give	re street and number)		4b.	City, Town,	or Location of Dea	ith	4c. Coun	ty of Death	
	Euroval	-	5. Social Security Number 6. S	Sex 7. AC	e (in yrs. last b	irthday) If U	Jnder 1 Year	If Under 24 Hr	8. Date of Bi	rth .	N/A	(State or Foreign
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	rland ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	n or Location	າ				10d. J	Inside City Limits
	e Mary Ba-f sh	ctor	MD Baltim	ore		Ва	ltimo	re				1 □ Yes 2 █ X No
	with the	by Funeral Director	10e. Street and Number 7140 Rolling Ben	d Rd., Apt	:. В	10	f. Zip Code	21244			What Country?	
	death	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was I	Decedent of	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or N	o- 14. Ra	ace - American II	ndian,
036	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show re Medical Evanis or must be redified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 1 If Yes, Give Year or Dates:	No		es 2 X No		nto Rican, etc.)	Spec	ack, White, etc. ify: White	e
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212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 8	5+) A	mbular				Hea1	thcare	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanir er must be rediffied at once.	To Be C	17. Father's Name (First, Middle, Last, Carl D. E. Hoff					ľ	_{ime (First, Middle} na Crauf	e, Maiden Surna	me)	
	nd 2 sho alth and I 27 is ma	ľ	19a. Informant's Name/Relationship (Type.Print) ter - Wife		-		et and Number or F Bend Rd				,
Baltimore,	es 1 a of Hear fitem		20a. Method of Disposition	15	20b. Place o	of Disposition ery, crematory	(Name of	ace)	Date	20c. Location	- City or Town,	State
Ë	Pag ment ant: h	1	1 Burial 2X Cremation 3 □ 4 ponation 5 □ Other (Specif			tic Cr	emato	ry Dec	. 11,201		en Burn	-
Balt	Departing Departing any Income.		2) In turb of Fulheral Service Lice	£205	W			ress of FacilityAm onds Fry			-	
9			23a. Part 1. Enter the disease, or com shock, or heart fallure. List only	plications that caused one cause on each li	the death. Do	not enter the	mode of dy	ring, such as cardia	ac or respiratory a	arrest,	Inte	proximate erval Between
	Physician		Immediate Cause (Final disease or condition	a Se	Otic	, SV	10C	X			O	set and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	1	1,-000	``	/	1	
7		er	Secuentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	Of):	X	NVOX	psi			ays.
D	ate be executed hysician and the burial-transit	Examiner	Securately list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting to death). Lead			_		()	and l	TVALUNE	1	
50.	e exe ian ar ırial-tı	Ex	resulting in death) Last	Due to (or as	a consequence	of):		OFFITTERCA O	prio Es u	THE ETHORNE		
8760	cate b	dical		d				CEKINION	In .			
4 ×	leath certifica attending ph for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy			,		T		
78	death atter	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal deatl		pic pregnan er <i>(specify)</i> _	ісу		I	ate of delivery Ionth Day	Year
70	that the de ned by the a detached t	hysi	1 □Yes 2 □No 9 □ Unknown	9 ☐ Unknown			, (opoony) _					
+ 6	ires that signed I		Part II. Other significant conditions of	ontributing to death b	ut not resulting i	n the underly	ing cause gi	iven in Part I.	23e. Did	tobacco use co	ntribute to the ca	use of death?
ecord	w requires been signal	ted	HOUTE KEY	lasta	iluvt	-)P	DVa	pregia	_ 10	Yes 2 □ No	3 ☐ Probably	4 Unknown
Rec	e la	Completed by							24a. Was auto perfo	psy prmed2	prior to comple death?	findings available ation of cause of
<u>a</u>		Bec	25. Was case referred to medical examiner?					26. Place of De	1 □ Yes ath (Check only	-	1□Yes 2	INO
中する			1 Mayes 2 No	Hospital: 1 Inpatie		utpatient 3	_ DOA		Home 5 ☐ Res		11 1/	
	Attending Physician: r death. ector: After this certific by the funeral director, I	ation:	27. Manner of Death TX Natural 5 ☐ Pending 2 X Accident investigation	28a. Date of Inju (Month, Date 2005	y, Year)	Time of Injury KNOWN M	28c. Inju Wo 1 [ıry at ırk Ünknown ∐Yes 2 □No	Subjec	t fell.	rred	
Division	p ag ic	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc	ury - At home, fa c. (Specify)	ırm, street, fa	ctory, office		28f. Location (City or To	Street and Num wn, State)	nber or Rural Ro nknown	ute Number,
	e Hospital	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	yslcian: To the best niner: On the basis o and manner sta	f examination ar	e, death occu nd/or investig	irred at the t ation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and r date and place	nanner as stated , and due to the	d. cause(s)
	Fo the vithin 2 Fo the comple	Me	29b. Signature and title of gertifier	MA			29c. Licen:	se number		29d. Date sign	ed (Month, Day,	Year)

use of death (Item 23a) (Type, Print)

Ave Baltimore, MD 21729

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 20 TO 11:59 AM Richard Dix Hardin Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner **Baltimore** Gilchrist Hospice Towson 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 🖾 M 2 🗆 F Months Days Hours Min. Oct 9, 1926 West Virginia 84 Director 220-16-6330 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2 No 10f. Zip Code 21234 10e. Street and Number 10g, Citizen of What Country? Funeral 3019 California Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11 Marital Status Armed Forces? 1944 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 1946 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) liquor should be filed with and Mental Hygien is marked other th bartender 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev မ Mary Frances Lowery George Henry Hardin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3019 California Ave; Parkville, Maryland 21234 Denise K. Hardin - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature II. neral Service Licens Walter 22. Name and Address of Facility State Anatomy Board irector 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) NGESTIVE Due to or as a consequence of): DARC Medical Examiner Sequentially list conditions, if any, and ingle immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 5 Other (specify) Month Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC KIDNOY DISEASP Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed CHROWIC OBSTPUCTIVE PULLMONARY DISEASE 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?

1 ☐ Yes 2.☐ No CORONARY Yes 2 E 25. Was case referred to medica examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be HESPICE Hospital: Other: 4 Nursing Home 5 Residence ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide iniury 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Destifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

JAN 25

2011

Registrar's Signature

SPETH CHARLES STRUET BALTIMORE MD 21704

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 5 2010 8:06 Ам December **Physician** Paul John Heilman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore **Examiner** 3731 White Pine Road; Apt. B Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Days Min Months **Funeral** 1⊠M 2□F Maryland Sept 19, 1941 69 212-40-4649 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10h. County 10a. State 1X Yes 2 No Baltimore MD Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21220 3731 White Pine Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. 11 Marital Status 1 ∐Yes 2 2 XINo If Yes, Give Year or Dates: white 1 X Never Married 2 ☐ Married Specify: 1 ☐Yes 2X No Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced 16b. Kind of Business/Industry un 16a. Decedent's Usual Occupation unli Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angela Sarah Hasset Frank Edward Charles Heilman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3731 White Pine Rd Apt Bl Baltimore, MD 21220 Angelina Baldwin - niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5⊠Other (Specify)in state 22. Name and Address of Facility State Anatomy Board Ronald Wade ector 655 W. Baltimore St; Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each in e. DRI Immediate Cau (Final disease or condition resulting in death) Neumoni **Physician** Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant Month 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Tyes 2 No s been signed by the s should be detached t 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Residence 6 Other (Specify) examiner? Other: Hospital: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Injury 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide filled in by 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

Medical

31. Date filed (Month, Day, Year)

JAN 2 0 2011

W.ma

29b. Signature and little of certifier

29a. Certifier

Derus

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and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Buto

sulte c

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 27,29a per dr., g911,01727/2011dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December a.M. 20/*U* 9:22 Cynthia Ann Kumar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** - Ugnes Health HIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F Hours May 23, Day 969 Country) Maryland 41 **Director** 217-62-6363 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No N/A Baltimore MD 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3154 Strickland Street 21229 USA items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify. 3 Widowed 4 Divorced Specify: Completed Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Caregiver Chase Home 11th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Cheak, Sr. Bernice Joan Piper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marrio Williams - Fiance 3154 Strickland Street Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Green Mount Cemetery 1/10/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility 21. Signature J Fundal Ferrice Lo 22. Name and Address of Facility Chattren Harris Funeral Hore 5240 Reisterstown Road Baltimore, Maryland 21215 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Cause (Final Cause (Final Cause)) Approximate Interval Between Onset and Death 12/21/2010 Physician/ Compliations -Medical resulting in death) Due to (or as a consequence of) Examiner HTN Sequentially list conditions, if any, leading to immediate cause Enter Indentity in Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit Physician/Medical Exam DIADETES KUM&() (ハルル ギンセ), Division of Vital Records, P.O. Box 68760 that initiated events Due to (or as a consequence of): resulting in death) Last requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No the 9 Unknown be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director: Atter this certilizate new completed filled in by the funeral director, page 2 should in 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 1 🗶 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination allows investigation, in the control of the cause (s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTCAN Dezartment timer jene, ST Agnes (some man)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

1881 27

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 28f per me, g921, 11/01/2011dhb

Certificate of Death

Reg. No. 1 - For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 0534 M **Physician** 2 2010 LANTZ 29 CHRISTOPHER STEUGN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Garrett Memorial Garrett Count Bakland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number (In yrs. **Funeral** Days Hours 25 219-08-5222 29 1985 Oakland, MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show ral", or items 23a or 28a-f shov 1 XYes 2 No Directo 0akland MD Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21550 77 W Pennington Street Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No 'natural", or Specify: White If Yes. Give þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical within 72 Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1aw permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygien Important: If item 27 Is marked other thany injury or other traumatic event, the student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Crum Steven Lantz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 77 W Pennington St, Oakland, MD 21550 Steven Lantz-father Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 01/01/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home P.A. 21 N. 2nd St, Oakland, MD 21550 duck 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) sow not a VOCK IN JURY **Physician** ACCI DONT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28d Describe how injury occurred snow mobile Crashed into wire fence 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? After 5 ☐ Pending investigation 1 ☐ Natural 0320 M 1 ☐ Yes 2 ☐ No death. 12/29/10 spital or Attendi nours after death. neral Director: A / filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Farm Field 28f. Location (Street and Number or Rural Route Number, City or Town, State) 775 Kings Run Rd. 4 Homicide Oak land Mb s Reural and due to the cause(s) and manner as stated. To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

ler DO 69 Wolf Acres Drive Oak land MD 21330
32. Registrar's Signature

Denne B. Jak

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible,

Barry R Livengood	1- For State Registrar	ate of Maryla		ment of icate of		Mental H		Reg. No.	U 3129
Physician/ Medical Examine	1. Decedent's Name (First, Midd Barry Ray Live			•			2. Date of Dea	Day Year	3. Time of Death 1320 hrs
	4a. Facility Name (if not institution 416 Roanoke Avenue	on, give street and num	nber)	41	o. City, Town, or Lo	ocation of Death		4c. County of De Garrett	
Funeral Director	5. Social Security Number 220-92-4687	6. Sex 7	7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min.			Birthplace (State or Foreign Country) Maryland
and show any acc.	Usual Residence of Decedent 10a. State 10b. County MD Garre	++	10c. City, Tow	vn or Locatio					10d. Inside City Limits 1 X Yes 2 No
eath with the Maryland liens 23s or 28s-f sho ust be notified at once.	10e. Street and Number 416 Roanoke Av		11011	- Bake	10f. Zip Code 21550		1	10g. Citizen of What C	
fter d	11. Marital Status 1 Never Married 2 M	12. Was Dece	dent Ever in U.S. rces?	If Ye	Decedent of Hispa s, specify Cuban, M	Mexican, Puerto		0- 14. Race - Ar White, etc	nerican Indian, Black, c. Thite
5-0036 ed within 72 hours a tygiene. other than "natura the Medical Examira Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12	cify only highest grade	4 or 5+)	a. Decedent's during mos	s Usual Occupation at of working life. D	n (Give kind of w OO NOT use retir	vork done red)	16b. Kind of Busine Manufact	
	17. Father's Name (First, Middle, William Ray Li 19a. Informant's Name/Relations	vengood	•		18 L	inda Ga:	il Schr	Maiden Surname)	
2 78 9 9	William R. Liv 20a Method of Disposition	engood/Fat	her 20b. Place	203 Rc	anoke Av	e., Mtn		mber, City or Town, St Park, MD 20c. Location - City	21550
Baltimore, permit Pages La Department of He Important: If ite injury or other the	1 Burial 2 X Cremation 4 Donation 5 Other S 21. Signature of Euneral Service	pecify: Licensee	Count	-	de Crema			011 Davids	
M 됩러표를 Physician	23a. Part I. Enter the disease, or	peumo connications that can			Box 27				Approximate Interval
/Medical Examiner	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	Alcohol					ost, shock, of flear	Between Onset and Death
50, te be executed ysician and burial - transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Due to (or as a c							
50, te be executed sysician and burial - transit	X UNPENDED	d AMENDED	23a,27,28	Ba-f p	er me g91	13 3-2-1	1 vt		
of Vital Records, P.O. Box 68760, ig Physician: The law requires that the death certificate be executed ther this certificate has been signed by the attending physician and nertal director, page 2 should be detached for use as the burial - transit: To Be Completed by Physician/Medical Ei:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unit	e 1 Live birt	nt at time of death	2 Feta	I death 3	Ectopic pregnar	ncy	23d. Date of deliv	very Day Year
ires that the signed by the detached by by the detached by the betached by the by the by the by by by the by by by the	Part II. Other significant conditi	ons contributing to c	death but not resulti	ing in the un	derlying cause give	en in Part I.			to the cause of death?
of Vital Records, P.(in Physician: The law requires tha ther this certificate has been signed meral director, page 2 should be det To Be Completed by							24a. Was autop perfor 1 Yes	osy prior death	
Yital Receptors of the continuous of the control of	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inp		Outpatient	3 DOA Ot		Home 5	Residence 6 🗸 Ot	her: Scene
ᆫᅾᇃᇰᄰᆝᆼ	. 🔽	tigation Id 12	Injury Pay,Year) -28-10 f o of Injury - At home,		pm 1 Yes	2 X No	unknow 28f. Location (\$	Street and Number or	Rural Route Number, City
9-3>	4 Homicide 29a. Certifier 1 Certifying Ph	mined (Specify) yslcian: To the best of	resid	lence	d at the time, date	and place, and	or Town, S Mt. La	ke Park, M	noake Ave. d. 21550
To the Hos within 24 h To the Fun completely	one) 2 Medical Example 29b. Signature and title of certifie	niner: On the basis of and manner state	examination and/or ted.	investigatio	29c, License n	number		29d. Date signed (Month, Day, Year)
	30. Name and address of person Theodore M. King, Jr.,	_	of death (Item 23a)		O.C.M.			December 29,	2010
State			strar's Signature	/	JO VI. DAILIIIO	Olleet, Da		, E 1223	

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene me, g911,01/21/2011dhb Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ ARGARE A-2011 Month MBCZ Day 30 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Lexistington medical Center Arundel unie 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) 1 🗆 M 2 🗹 F Months Hours Min Director 213-12-0683 MARY LAND Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f sl Examiner must be notified 1 ☐ Yes 2 🗹 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21 STEVENS J.S.A 21060 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced shiTK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ZI STEVENS RD. GLEN BLANKE, んeしいら、 Saltimore, N MD. 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-1-10 ODENTOW MD. of Ineral Service Vense 21. Sign 22. Name and Address of Pacility Daugh ERTY FUNE AND HOME 2601 MOUNTAIN 25. PASADENA 23a. Part 1. Enter the disease, or conthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of) PAIN Examiner Sequentially list conditions, Examine if any, hading to immedia cause. Enter Underlying Cause (Disease or iinjury FRATURE INTER TROK burial-transi that initiated events resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending 11/19/2010 injury work? 1 ☐ Yes 2 🔀 No Unknown M Subject fell 2 X Accident Investigation completed filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 21 Stevens Road Glen Burnie, MD determined within 24 hours To the Funeral cal 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year)

November 32 2010 29b. Signature and title of certifier 29c. License number D 43149 Mi and address of person who completed cause of death (Item 23a) (Type, Print)

ABATO 301 Not putal of the Gien Burne Mi) 20161

State Registrar 31. Date filed (Mont)

. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 2010 Lee Roy McCloud 1507 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death Garrett County Memorial Hospital 0akland Garrett 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 6. Sex 1 **X** M 2 □ F Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Birthpiac Country) WV **Funeral** Months Days Hours Min. Director 916 232-07-7630 Usual Residence of Decedent shov 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits

1 Yes 2 No

USA

14 Race - American Indian

Black, White, etc.

Elk Garden, WV

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

29d. Date signed (Month. Dav. Year) 1/3/2011

Approximate Interval Between Order and Death

Specify: White

coa1

: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director WV Mineral Blaine 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 26767 Railroad Street death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Armed Forces?

1 M Yes 2 No
If Yes, Give 1 942
Year or Dates. 1945 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygbers. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examirany injury or other traumatic event, the Medical Examirans in injury or other traumatic event, the Medical Examirans in injury or other traumatic event, the Medical Examirans in the δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 miner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Henry McCloud Jessie Belle Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha McCloud-wife Po Box 606, Kitzmiller, MD 21536 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place IOOF Cemetery 1/3/2011 21. Signature of Funeral Service Licen. 22. Name and Address of Facility David A. Burdock Funeral Home P.A 21 M/ 2nd St, Oakland, MD 21550 23a. Part/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause of Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner 1) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a, Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🔲 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural Natural 5 Pending work? 2 🗌 No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I only one)

29b. Signature and title

ame and address

State Registrar Goralski M.D., 311 North Fourth St, Suite II, Oakland, MD 21550

of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 State of Manyland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Moffett Joyce 3:37 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Union Memorial Hospital **Baltimore** Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Days MD Country) 215-42-7296 Director 10/26/1944 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2708 Oakley Avenue 21215 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Yes 2 X No Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 1 and 2 should be filed within 72 hours of Health and Mental Hygiene.
If item 27 is marked other than "natural" if item 27 is marked other than "matural". 3 X Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Psychiatric Aid Univ. of MD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lonnie Proctor Ford Rosalie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5518 Lynview Ave., Baltimore, MD 21215 Kasha Sawyer - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1-Department of I Important: If It any injury or of cemetery, crematory or other place)
Garrison Forest 1 X Burial 2 Cremation 3 Removal from State 01/13/2011 Owings Mills, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph H. Brown Jr., **Funeral** Dietrich williams per DVR Home, PA., 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician. electrical ulseless disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner vocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam attending physician and for use as the burial-transit Aspiration theumonia that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year ned by the a 9 Unknown P.O. signed It Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? certificate 2 No Yes 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital Other: မြ After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural 5 Pending injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 2 Acciden
3 Suicide Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 2438946 ther 21218 Baltimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) union memoria 32. Registrar's Sanature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25tate of Maryland / Department of / 28/2011 drb Hygiene Certificate of Death

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Michael Joseph Pucci 12:23 December A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Parkville **Examiner** 4c. County of Death

Baltimore 2213 Lowells Glen Road, Unit B If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
August 30, 1925 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 15√15√1 M 2 □ F 218-12-7351 85 Yrs Balt. Maryland Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore Parkville 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country?
United States "natural", or items 23a o Funeral 2213 Lowells Glen Road, Unit B 21234 of America filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify Specify white Completed 3 Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Baltimore City pernit, Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Police Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Peter Pucci Ann Biscotti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina R. Pucci/daughter 6740 Bessemer Avenue Baltimore, Maryland 21222 Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Oak Lawn Cemetery f Ineral Servic Peaceful Alternatives Funeral and Cremation Ctr.PA. 2325 York Road Timonium, Maryland 21093 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ ntracrania hemorrhane disease or condition Medical resulting in death) Due to (or as a consequence of) 2 days Examiner Sequentially list conditions, if any leading to immediate CERTIFICATION APPROVEDED MEDICAL EXAMINER Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal deat
Pregnant at time of death
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year signed by the a d be detached f 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes XXNo 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2XX No certificate 1 ☐ Yes 2XXNo ours after death.

eral Director: After this certificatilled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XXResidence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
 Accident 5 Pending iniury 12/29/2010 **Unknown**M Subject fell Investigation 6 Could not be Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Unknown Unknown within 24 hours a Medical X Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Qertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

			For State Registrar	amend 73	State of M	i 6911 larylan		/2011 j artment o <i>rtificate</i>			Mental H	ygiene Reg. No.		4313	} 4
				ne (First, Middle, La	st)						2. Date of D	eath		3. Time of D	eath
П	Physicia /Medic		Peter	James Pi	Eeiffer						Month	Day her 3	y Year 20, 2010	8:06	лм М
1	Examin				e street and number)		4b. City, Tov	wn, or L	Location of Dea			County of Dea		71.1
رر			1305	Blossom I)rive			Jopp	oa				Harfor	d	
	Funeral		5. Social Security I		Sex 7.A	ge (In yrs. l	a <i>st birthd</i> ay) Yrs.	If Under 1		If Under 24 Hr Hours Mir		irth ay, Year)		thplace (State or ountry)	
	Director	-	187-07-9 Usual Residence of	1434			115.				Aug 20	, 172	.0 161	IIIIS y I Vaii.	La_
	low	ı	10a. State	10b. County		10c. City	, Town or Lo	ocation						10d. Inside City	Limits
	Many a-f sh	tor	MD	Harfor	d	Joj	ppa							1 □Yes 2	No
	or 28	jrec	10e. Street and Nu	mber				10f. Zip Co					izen of What C	ountry?	
	23a (23a (23a (23a (23a (23a (23a (23a (la	1305 B	lossom Dr	ive			210	85			U	SA		
	uges I and Z stoud be filed within 7.2 hours after dean with the maryland the file Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Mar 3 ☒ Widowed	ried 2 Married	12. Was Decedent Armed Forces 1 AYes 2 If Yes, Give Year or Dates:	0	2-	Was Deceden If Yes, specify 1 ☐ Yes 2 ☑		spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	lo-	14. Race - Am Black, Whit Specify: V		
	atura ical E	ted	(0	15. Decedent's Ed	ducation		16a. Dece	dent's Usual C	Occupat	tion		16b. K	ind of Business	/Industry	
	ygiene. rer than "n t, the Med	Completed by	Elementary/Sec 12		College (1-4or 4	5+)		tind of work of DO NOT use i		uring most of w		A	Inited S		
	Mental H arked oth	To Be		(First, Middle, Last m Randall	Pfeiffer	Sr.					ame (First, Middl				
	aumi aumi			lame/Relationship (Rural Route Num				
•	and Health m 27 her tu			. Pfeiffe	er - son	1					ppa, Ma				
	perniit. Pages I and Z Department of Health a Important: If item 27 is any Injury or other trai				Removal from State	20b. P	lace of Dispo emetery, cre	osition (Name matory or othe	of er place,		Dat <i>e</i>	20c. Le	ocation - City o	r Town, Stat <i>e</i>	
	Depart Import any Inj		21. Signature of E	uneral Service Lice	Wade, Di	rector	2				tate Ana e St; Ba	_		21201	
	hysician /Medical		23a. Part 1. Enter shock, of he Immediate Cause disease or conditi resulting in death)	art failure. List only Æinal on	plications that cause one cause on each	line.	MYE		of dying	, such as cardi	ac or respiratory	arrest,		Approximate Interval Betwo	eath
	attending physician and for use as the burial-transit	ical Examiner	Sequentially list or if any, leading to ir cause. Enter Und Cause (Disease o that initiated event resulting in death)	onditions, nmediate erlying r injury s Last	b. Due to (or as		,								-
1000	The law requires that the death cellineate be executed at the best signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	? months? □ No	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 🗌 Fetal	death 3	□ Ectopic prec □ Other (spec					23d. Date of de Month	-	ear
1 1 1 1 1	has been signed by the		Part II. Other sign	ificant conditions	contributing to death	but not resu	Iting in the u	inderlying caus	se giver	n in Part I.				to the cause of de	
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F	cate has t	Completed by										opsy form <u>ed</u> ?	prior to	utopsy findings av completion of cal s 2 □ No	vailabl use of
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Towns of Land	eath. or: After the funera	Certification: To	27. Manner of Dea 1 ■ Natural 2 ■ Accident 3 ■ Suicide	th 5 □ Pending investigation 6 □ Could not b		ay, Year)	28b. Time of Injury	М		at ? ′es 2 □ No	28d. Describe	how inju	ry occurred		
And an At	rs after d al Direct led in by	Certifi	4 Homicide	determined	28e. Place of Ir building, e	ijury - At ho tc. <i>(Specif</i>)	me, farm, st	reet, factory, of	ffice			(Street ar own, State		Rural Route Numb	er,
Sec. Manual	within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)	1 ☐ Certifying Pl 2 ☐ Medical Exa	nysician: To the bes niner: On the basis and manner s	of examinat	wledge, dea tion and/or in	th occurred at ovestigation, in	the tim n my op	ne, date and pla pinion, death oc	ce, and due to the curred at the time	ne cause(s e, date an	s) and manner and du	as stated. ue to the cause(s)	
1	To t	Z	29b. Signature and	title of certifier	La mo					number 088		29d. Da	ate signed (Mor	nth, Day, Year)	
					completed cause of m Johns H				Be	lcamp.M	D 21017		, ,		

Registrar DHMH 17 Rev 1/2001

State

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		•	For Amend State Registrar	Iten	is 25,27	286 ^y		51190 192 tificate of	18921011101 11 Death		Reg. No.	10 43135
	Physicia	n/	1. Decedent's Name (First,		•					2. Date of Dea		3. Time of Death
	Medic	al		RANDO						DECEMBE		2010 11:00 P M
	Examin	er	4a. Facility Name (if not inst TALBOT HOSP	_		nber)		4b. City, Town, EAST(or Location of Deatl	ר	4c. County	
	Funeral		5. Social Security Number	6. 8	Sex 1 □ M 2 双 F		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birt	h .	Birthplace (State or Foreign Country)
	Director		113-18-5916 Usual Residence of Decede		I L M 2 X F	93	Yrs.	Wichtis	Tiodis Willi	10/29/	1917	NY NY
	and show dat	rot	10a. State 10b. C			10c. 0	City, Town or Lo	cation				10d. Inside City Limits
	Maryl 28a-f otifie	Director		AROL	ENE		DENT	ON				1 ☐ Yes 2 🔀 No
	th the 3a or t be n		10e. Street and Number					10f. Zip Code			10g. Citizen of	
	ath wi	Funeral	24703 PEALI	QUOR	_	edent Ever in l	J.S. 13. \	2162 Vas Decedent of		pecify Yes or No-		states ce - American Indian,
9	ter de	by F	1 Never Married 2	Married	Armed Fo	orces? 2 X No			Hispanic Origin? (Spoan, Mexican, Puert	o Rican, etc.)	Blad	ck, White, etc.
21215-0036	ours af tural" al Exa	ted	3 X Widowed 4 □ Div		If Yes, Giv Year or D			Yes 2 X N			Specify	WHITE
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212	within giene. er tha , the [Elementary/Seconday (0	1-12)	College (1 5+	-4 or 5+)	1	OL TEACI	•		EDUCAT	ION
	e filed tal Hy ed oth event	To Be	17. Father's Name (First, Mi	, ,						me (First, Middle,		e)
Maryland	uld be d Men marke matic	-	WILLIAM E. 19a. Informant's Name/Rela							M. SMITH		
Ma	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		ANNE-MARIE C	• •		ITER		-	t and Number or Ru JOR ROAD,			State, Zip Code) 629
Baltimore,	ge 1 and it of Hea if item or othe		20a. Method of Disposition 1 ☐ Burial 2 🗶 Crem	0.	7.016	20b	. Place of Dispo	sition (Name of	!	Date		- City or Town, State
tim	Page tment tant: I jury o		4 ☐ Donation 5 ☐ O	ther (Spec	ify)	State CH	ESAPEAK CENT	E CREMAT	TON 01/0	3/2011	STEVENS	VILLE, MD
Bal	permit. Page 1 Department of Important: If i any injury or conce.		21. Signature of Funeral Sé	rvice Licer	1900	12.		Name and Addr	HELFENBEI	N & NEW	NAM FUNE	ERAL HOME, P.A.
			23a. Part 1. Enter the disea shock, or heart failure	ise, or con	nplications that	aused he de			HARRISON ing, such as cardiac			Approximate
	Physician/	ļ I	Immediate Cause (Final disease or condition	. LIST ONly			ON FROM					Interval Between Onset and Death
	Medical Examiner		resulting in death)		Due to	(or as a conse	quence of):				62	
		er	Sequentially list conditions if any, leading to immediate		U. —	(or as a conse		<u>CEREBRAI</u>	, HEMORRH	AGE	11	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	5					\cap	· 1	TOICAL EXAMINE	ER
	s executed vian and urial-transit	- 1	resulting in death) Last	ı	Due to	(or as a conse	quence of):		- THE CAN	M APPROVED BY	WEDIO.	
68760	cate be physicia the bur	edic		•	d	_			CERTIFICA	,		
.89	h certifica tending p	ľ/W	IF FEMALE: 23b. Was decedent pregnar	nt	23c. If yes, ou	tcome of preg	nancy	1	-		23d. Da	ate of delivery
Вох	death ne atte ad for	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 🗶 No			nant at time o		Ectopic pregnar Other (specify)	ncy			onth Day Year
P.O.	that the de		9 ☐ Unknown Part II. Other significant co	onditions of			esulting in the u	nderlving cause o	given in Part I.	23e Did to	phacco use cont	tribute to the cause of death?
s, P	6 5 6	Completed by						, ,				3 Probably 4 N Unknown
ord	aw requirer as been sig 2 should b	plete								24a. Was		Were autopsy findings available
Records,	The la cate ha page 3	Com									rmed?	prior to completion of cause of death? 1 ☐ Yes 2 👿 No
of Vital	sician: The certificate rector, pag	Be	25. Was case referred to me examiner?	edical	Hospital:				Place of Death (Che			
of V	y Physicia or this cert eral direct	e: 10	1 X Yes 2 X No 27. Manner of Death		28a, Date	of injury	ER/Outpatier 28b. Time of	t 3 DOA 28c. Inju	4 ☐ Nursing F	lome 5 Resid		ner (Specify)HOSPICE
on	Attending I death. ctor: After y the funer	ficat	2 🔼 Accident li	Pending nvestigation	n 12/28	th, Day, Year) 3/2010	Unknov	m _M wo	rk? ☐ Yes 2 X No	FALL		
Division	I or Attend after death Director: / d in by the f	Certificate:		Could not l letermined	28e. Place buildi	ng, etc. (Spec		et, factory, office		28f. Location (S City or Tow	Street and Numb	er or Rural Route Number, 03 PEALIQUOR RD.
۵	Hospital or 24 hours afte Funeral Dir sted filled in		29a. Certifier 1 X Cer	tifying Phy	ysician: To the b	est of my kno	wledge, death o	occured at the tim	e, date and place, a	and due to the car	DENT use(s) and mann	ON MD ner as stated.
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completed filled in by th	Medical	(Check 2 ☐ Med only one) 3 ☐ Cer	lical Exam tifying Nu	niner: On the bas	sis of examinat	ion and/or invest	igation, in my opir	nion, death occurred the time, date and pla	at the time, date a	nd place, and du	e to the cause(s) and manner stated
	with con		29b. Signature and title of c	ertifie	/.				se number		_	d (Month, Day, Year)
U	TIS		30. Name and address of pe	erson who	completed com		em 23a) (Type F		488		12/31	/ 2010
	5		WAYNE D. BE				, , , , ,		D., CHEST	ERTOWN,	MD 2162	20
	Stat Registra		31. Date filed (Month, Day, Y	ear)	32. F	egistrar's Sigr						
	negistra	T.	JAN	10 E	UTI LA	news	J. J	~				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 31,2010 Physician/ 1:05PM Leonard Roache, Jr. Philip Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Brighton Gardens-Bethesda Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Oct 2, Months Min 1 X M 2 - F Director D.C. 217-44-0580 94 Usual Residence of Decedent 28a-f show 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No M D Montgomery Silver Spring 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 20906 USA 3330 N. Leisure World Blvd. #11 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Completed WWII era Year or Dates. the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Government Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Agnes Roache Philip Leonard Roache, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MD 21076 Philip L. Roache/Son 6001 Bakers Place, Hanover, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/6/2011 1 😾 Burial 2 🗌 Cremation 3 🗌 Removal from State any injury or Gate of Heaven Cemetery Silver Spring, MD 4 Donation 5 Other (Specify) Francis Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Inc. Spring, MD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, not one cause on each line. 23a. Part 1. Enter the disease, or Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final Physician/ disease or condition resulting in death) Advanced Dementia Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) requires that the death certificate be executed Cause (Disease or iinjury physician and s the burial-trans Coronary Artery Disease that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Year Month Day Pregnant at time of death 5 Other (specify) the 2 1 Yes 2 L 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X page 2 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4K Nursing Home 5 Residence 6 Other (Specify) ည 2 x XNo 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at injury thin 24 hours after death.

the Funeral Director: Afte 1X Natural 5 Pending work 1 Yes 2 No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) Jan. 3, 2011 D30132 M-D

State Registrar

Rita

31. Date filed (Month, Day, Year)

Ghosh,

Box 68760

P.O.

Records,

Division of Vital

14812 Physician's Lane, #161, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year **Physician** 8,301 2011 /Medical 4b. City 4c. County of Death own, or Location of Death Name (If not institution, give stre Examiner If Under 24 Hr 9 Birthplace (State **Funeral** Hours Months Days 1□ M Director Usual Residence of Deceden 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other treumatic event, the Medical Exemple rust be notified at 1 ☐ Yes 2x No Completed by Funeral Director Rockville MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20852 6 Hitching Post Place Items 23e 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1☐ Yes 2☐ No Baltimore, Maryland 21215-0036 ō Specify Specify: white Year or Dates: Widowed 4 ☐ Divorced "naturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) education 12 teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be If Health and Mental Julia MacGregor Archibald Hawkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6 Hitching Post Place; Rockville, MD 20852 Margaret Hood - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State permit. Pages Department of HImportent: If Ite any injury or of once. 21. Signaturê of Funeral S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 10 Approximate Interval Between Onset and Death hart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Sause (Final disease or condition resulting in death) Colonery Pnysician Discuse /Medical Due to (or as a consequence of **Examiner** 114 2 fension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the funeral director, page 2 should be Partinson 1)150632 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. after death 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 | Homicide within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M \wedge 00064624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAITHEASBURG WALK DA 743 SANDEEP SUMMER SHARMA State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day ZGI ZOIG LOUPM Decembe **Physician** B REAVER /Medical 4a. Facility, Name (If not institution, give street and number)
Baltimore Washington Medical
Center 301 Hospital Drive

5 Social Security Number 6. Sex 7. Age (In vrs. las 4c. County of Death 4b. City. Town, or Location of Death Examiner Glen Burnie 21061 monde Anne If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Year) Days 1 M 2X F March 20, 1916 Maryland Director 215-10-7160 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at once. 1 ☐ Yes 2X No Glen Burnie Director MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21061 122 1st Avenue West Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2≦ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: δ 3 P Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) financial savings bond clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Barbara Sarah Fischer Harmon Rodolph Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Winton Ave; Ferndale, MD 21061 Barbara Ann Matti - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature Funeral Struce Lice 198 655 W. Baltimore St; Baltimore, MD 21201 attl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ Mo 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Vijo 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 00 Impatient 2 ER/Outpatient 3 DOA After this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Exitiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, JAN 2 Year)

titte of certifie

29b. Signature and

30. Name and addre

of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are I					_
State of Maryland / Department of Health and Mental Hygiene	2.0	10	1.3	13	9
Certificate of Death					

		1- For State Registrar	Certificate	of Death		R	eg. No.	
Physicia	ın/	Decedent's Name (First, Middle,Last)			•	2. Date of Dea	th	3. Time of Death
Medical Examii	ner	Doris Rudensky				Month Septembe		1845 hrs
		4a. Facility Name (if not institution, give street and numb Carrol Hospital Center	er)	4b. City, To Westm	wn, or Location of iinster	Death	4c. County of Dear	th
Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthda	y) If Under	1 Year If Under	24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bi	
Director		220-68-0546 1_m 2XF	52	Yrs. Months	Days Hours	Min. Oct 2	3,1957 Fore	ign ountry) MD
5	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c, City, Town or L	ocation				10d. Inside City Limits
w any			TOO. City, Town or E					1 Yes 2 YNo
Aaryland 28a-f show Lat once,	ģ	MD Carrol1			ykesville			- 11
Mary r 28a ed at	Director	10e. Street and Number		10f. Zip C		1	Og. Citizen of What Cou	untry?
th the Maryland 23a or 28a-f she notified at once		6655 Sykesville Road - H	itchman B		21784		USA	
h wit	era	11. Marital Status 1 Never Married 2 Married Armed Force				n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Ame White, etc.	rican Indian, Black,
r deat	Funeral	1 Yes	2 X No		_	donto (nodin, oto.)		
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1		No specify:			nite
hour	E G	15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12) College (1-4)	durir		ccupation (Give ki ng life. DO NOT u		16b. Kind of Business	rindustry
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	Completed	2	31 317	None			None	
15-0036 filed within I Hygiene. Id other tha	탉	17. Father's Name (First, Middle, Last)			18.Mother's	Name (First, Middle, I		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Roman Rudensky			Ver	ronica E.	Jacob	
21215 ould be fill I Mental H i marked ic event, t	- 6	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address	(Street and Numb	er or Rural Route Nur	nber, City or Town, Stat	e, Zip Code)
MD 2 nd 2 shou alth and N m 27 is n numatic	- 1	Doris Rudensky (Patients	Record) 60	555 Syke	esville H	Road, Syke	sville, MD	21784
ang ang lead	Ī	20a. Method of Disposition	20b. Place of Di	sposition (Name or other place)	of cemetery,	Date	20c. Location - City o	r Town, State
nor Pages ent of nt: 11	- 1	1 N Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify:	Jiale		emeterv	9/8/2010	Sykesvill	e MD
Baltimore, permit. Pages I an Department of Hea Important: If itee	ŀ	21. Signature of Funeral Service, Licensee	DP128	22. Name and A	ddress of Facility	IATCHT FIIN	EDAL HOME 9	CHADEL DA
	1	Brian L. Hauset M	00764	PO Box	195 Syl	kesville.	ERAL HOME & MD 21784	CHAPEL, PA
Physician		23a. Part I. Enter the disease, or complications that caus failure. List only one cause on each line.	ed the death. Do not en	ter the mode of	dying, such as car	rdiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
edical aminer	-		plications of Muli	tiple Blunt F	orce Injuries			Death
aiiiiiei	-	or condition resulting in death) Due to (or as a co						
ž.	_	Sequentially list conditions, if any, leading to immediate Due to (or as a co						
	<u> </u>	cause. Enter Underlying Cause	isequence or).					
d Sit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a co	nsequence of):					1
8760, ificate be executed g physician and s the burial - transit		d			1001001			
O, be ey sician	g		28ĉ per me,	,g911,01	./20/2011	ldhb		
			come of pregnancy	Fotal doath	3 Ectonics	oregnano.	23d. Date of delive Month	ry Day Year
Sox 68 death certif	cial	4 Pregnant	at time of death 5	Other (Specif		pregnancy	World	buy rou
Box 68 e death certi the attendin ed for use as	Physicia	1 Yes 2 No 9 V Unknown 9 Unknown		J Gallet (1-prin)	,			
ਦੇ ਨੂੰ ਦੇ		Part II. Other significant conditions contributing to de	ath but not resulting in	the underlying c	ause given in Part		bacco use contribute to	
s, P.C lires that 1 signed t	ğ b				_	1 Yes	s 2 No 3 Pro	obably 4 🗹 Unknown
rds	Completed					24a. Was autor		utopsy findings available completion of cause of
eco he law ate has age 2 sl	틹						rmed? death? 2 ✓ No 1 Y	res 2 No
	ωl	25. Was case referred to medical		26	Place of Death (C			
of Vital Records, ag Physician: The law required they this certificate has been signeral director, page 2 should be		examiner? 1 ✓ Yes 2 No	itient 2 🗹 ER/Outpa	tient 3 DO	A Other	Nursing Home 5	Residence 6 Othe	er:
ision of Vital Attending Physician: r death. ector: After this certif	֡֡֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֡֟֓֓֡֓֓֓֡֓֡֓֓֡֓	27. Manner of Death 28a. Date of I	njury 28b. Time		NKNOWN ^{rk?}		how injury occurred ped off a structure	
ion trendi leath. tor:	읥	1 Natural 5 Pending Unknown 2 Accident Investigation	UNKNO	WN	1 Yes 2 1	No Subject juin	ped on a structure	5
Division pital or Attendi ours after death, teral Director: /	ertification:	3 ✓ Suicide 6 Could not be 28e. Place of	Injury - At home, farm,	street, factory, o	office building, etc.	28f. Location (tural Route Number, City
Dispital tours tours filled	63 F	4 Homicide determined (Specify)	nknown			unknown, ,		
o T = 5		29a. Certifier 1 Certifying Physician: To the best of one) One) One) One) One)						
Within Comp	e l	and manner state	d			urred at the time, date		
	2	29b. Signature and title of certifier	m D		License number		29d. Date signed (M	
		pul of			O.C.M.E.		September 7, 2	010
		 Name and address of person who completed cause of Russell Alexander MD. Assistant Med 		111 Ponn C4	reet, Baltimor	- MD 21201		
Sta	to.		- Annual Control		DaitiiiiOi			
Registi	ar	31. Date filed ANN, 2 Year 11 32. Regis	trar's Signature					

Physician
/Medical
Examiner

Funeral
Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event. If the Hacifical Examination ust be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

-	For State Registrar	State of N	Maryland		artmen <i>tificat</i>			and M	1ental I	Hygier Reg. 1	/ 11	0	43	40
ı	1. Decedent's Name (First, Middle, La	ast)							2. Date of				3. Time o	f Death
l	George	Harold	Son	R53					Month 12	2	9 2	010	7:35	рМ
	4a. Facility Name (If not institution, gi				4b. City,	Town, or	Location of	of Death		4	tc. County	of Death		
	Dennett Road Man	or Nursin	g Home	:	0a	k1an	1				G	arre	tt	
	,	Sex 7 1 X M 2 □ F	Age (In yrs. la	ast birthday) Yrs.	if Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month)	, Day, Yea	1923	9. Birth Cou WV	place (State ntry)	or Foreig
	Usual Residence of Decedent		10.00	~										
	10a. State 10b. County		10c. City	, Town or Lo	cation								10d. Inside C	2 X No
	WV Preston		Te	rra Al										2 20 140
	10e. Street and Number				10f. Zip					10g.	Citizen of		ntry?	
	RT 1 Box 404				26	764					US	A		
	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 \(\text{Yes} \) 2 \(\text{If Yes}, \text{Give} \)	s? ≰ No	"	Was Deced f Yes, sped I □Yes	cify Cubar	spanic Ori n, Mexicar Specify:	, Puerto	ecify Yes or Rican, etc.;	No-		ck, White,	can Indian, etc. ite	
		Year or Date	s:	160 Doors	lont's Hour	oi Occupa	tion			165	Vind of D		al materia	
	15. Decedent's E (Specify only highest gr	ade completed)		16a. Deced	kind of wo DO NOT us	rk done d	urina mos	t of worki	ing	100.	Kind of B	usmessar	idustry	
	Elementary/Secondary (0-12)	College (1-4d	or 5+)	L	farm	,					far	ming		
	17. Father's Name (First, Middle, Las	t)			татш		18. Mothe	er's Name	(First, Mic	ldle. Maid				
	Harold Sowers	,						know		, mara		/		
		(Time Print)		105 14 11	m A -1 -1	/Ct: :			-			04-1-	- 0- 1-1	
	19a. Informant's Name/Relationship	, ,,		19b. Mailin	•								b Code)	
	Julie Fike-neice 20a. Method of Disposition		205 0						ra Al				own Ctets	
4	20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec.		ie	ace of Disposemetery, crem			i		['] 2011		Thoma	,	own, State	
	21. Signature of Puneral Service Lice	SUACC	rck						id A.			Fune	ral Ho	me]
-	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	as a conseque	lero ence of).	st	mk	2_						Interval Be Onset and JWL YEAR	Death LKS
	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal It at time of de	death 3□	Ectopic p Other (sp					_		ite of deliver	ery Day	Year
F	Part II. Other significant conditions dialetes fract	contributing to death	but not resul	Iting in the un	nderlying co	ause give	n in Part I	hia	d	_	o use con 2 No	tribute to	the cause of	death? Unknow
	- U								a	Vas an utopsy erformed	,	prior to co death?	opsy findings ompletion of	availab cause of
	25. Was case referred to medical	<u> </u>					00.0:	-4.5	1 □Ye		No	1 🗆 Yes	2 □ No	
	examiner? 1 Yes 2 No	Hospital:	ationt ST			Othe			Check of					
	27. Manner of Death ↑★ Natural 5 ☐ Pending	28a. Date of l (Month,		ER/Outpatien 28b. Time of Injury	2	8c. Injury Work	at		me 5 TF 28d. Descr		6 □Otl	- ' '	ify)	
	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of	injury - At hor etc. (Specify	me, farm, stre	M eet, factory		′es 2□		28f. Locatio City or	on (Street Town, St	and Numi ate)	ber or Rui	al Route Nui	mber,
	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the be miner: On the basis and manner	s of examinati	vledge, death ion and/or inv	occurred vestigation	at the tim , in my op	ie, date ai pinion, dea	nd place, ath occur	and due to red at the ti	the caus me, date	e(s) and mand place,	anner as	stated. to the cause	(s)
	29b. Signature and title of certifier Nurguett	Hair	N	>	290	License	number 650	>					Day, Year)	
	30. Name and address of person who nurgareta kais	er md	13079		Print) H his	Theor	щ	oa	Klan	el,	ud	215	2010	
	31. Date filed (Month, Day, Year) JAN - 4	201 32. Regi	strar's Signati	uré	Land		/			,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Stat Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2010 26 0940 Patricia A. Scott Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1957Washington, DC 1 🗆 M 2 💢 F Days Hours Months Director 53 579-88-2648 May Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 1

Yes 2 □ No DC Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1563 41st Street S.W. 20020 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th CNA Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas James Annie Mae Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1903 Amberstone Court, Silver Spring, MD20904 Geneva Weaver/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date Chesapeake or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/30/10 Beltsville, MD Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AGEE/MCKINNON Funeral Service 3821 14th Street, NW, Washington, M00969 DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) a Acute Respiratory Failure Medical Due to (or as a consequence of) Examiner End Stage Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced several programs). Due to (or as a rour sequence of) as the burial-transi AIDS that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 4 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N After this certificate 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 **X**No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes မ 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 X Natural 5 \square Pending work?
1 Yes 2 Accident
3 Suicide 2 🗌 No Investigation 24 hours after deat Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 0 6 5 3 0 5 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/26/2010

State Registrar 31. Date filed (Month, Day, Year)

JAN 28

DHMH 17 Rev 7/2009

Nabila F. Khan, MD 1500 Forest Glen Road, Silver Spring, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 tate of Maryland, Dapartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 11:20 PM <u>Arden Franklin Shaw, Sr</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore City 2823 Maudlin Avenue Baltimore **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. 1 X M 2 🗆 F 09/08/1942 Mary Land **Director** 215-40-7186 68 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2823 Maudlin Avenue 21230 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Year or Dates. Completed by 1 ☐ Yes 2 🗓 No Specify: White 3 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 10 <u>Printer</u> Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pauline Irene Fields Arthur Edward Shaw, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2823 Maudlin, Ave., Baltimore, MD Lita Jean Shaw/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Services 101/06/2011 Hanover, Maryland 21. Signature of Funeral Service Licensee

Michael P. Mayulli 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Lost Physician/Medical Examiner Due to (or as a consequence of attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Dther (specify) ____ in the past 12 months? within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician; 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 N Residence 6 Other (Specify, 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATON AVE BALTIMORE MD 21229 AGNES 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State

Registrar

24

TOD: 2320 his

DOD:12/21/2010

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amend #2 per DVR G911 1/24/2011 IH
State of Maryland / Department of Health and Mental Hygiene [] | [] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2010 Month **Physician** 5:45 A M December John Franklin Thackston /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Kingsville 2602 Whitt Road Trunder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year)

Months Days Hours Min. Dec 1, 1934 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1X M 2 □ F Maryland 76 Director 212-30-9897 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinar is ust be notified at 1 ☐ Yes 2 No Director Kingsville MD Baltimore 10g. Citizen of What Country? USA 10e, Street and Number 10f. Zip Code 21087 2602 Whitt Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐Yes 2K No Specify. Specify: þ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) overhead crane operator steel worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Crockett John William Thackston ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 802 Melody Ct; Edgewood, Maryland 21040 Anthony Thackston Sr. - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Sign were of Funeral Service Rope I d e Sice Wade/Director 655 W. Baltimore St; Baltimore, MD 21201 e3a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** canc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by t 23e. Did tobaceo use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. è 2 🗌 No 3 □ Probably 4 □ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only e) Be Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 **N**0 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 701 who completed cause of death (Item 30. Name and address of person MONIUM 407 M 31. Date filed (Month, Day, Year) JAN 2 4 201 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

13 | 44

	an	1 - State Registrar 1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	Day	Year	3. Time of Dea
Medic		Laura Lynn Tarı			T		Decembe			8:48 AM
kamin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deatl	1		unty of Death	1
		7080 Lauren LAI			East				bot	
neral ector		219-02-8198	ex 7. Age ☐ M 2 🔀 F	(In yrs. last birthday, 42 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Sept 28	Year) 196	8 Mar	pplace (State or Fo intry) 'yland
- 22		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Li
ed at	ō	MD Talbot		Easton						1
iotili	ect	10e. Street and Number			10f. Zip Code			10a Citizen	of What Cou	intry?
ust be	Funeral Director	7080 Lauren Ln	[‡] 405		21601			USA		
E B	nu	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of I	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14.	Race - Amer Black, White	
any injury or other traumatic event, the Medical Examinar must be notified at once.	ğ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates:		1 □Yes 2 🛚 No				pecify: wh	
fical	Completed	15. Decedent's Ed (Specify only highest gra	lucation		edent's Usual Occu		kina	16b. Kind	of Business/I	ndustry
Mec	혈	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retire	ed)	inig			
4	ပ္ပ	12	0	ma	nagement				king	
even	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Sui	rname)	
atic	은	Marion Emerson 1		· · · · · · · · · · · · · · · · · · ·		Diane				
a a		19a. Informant's Name/Relationship (,, ,		ing Address (Stree					•
her ti		Marion E. Tarr	Jr - fathe		6 Heworth					
iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other Specification		20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	nce)	Date	20c. Locat	tion - City or I	lown, State
any inju		21. Signature of Funeral Service Licer	See Tyle	ctor	22. Name and Addr _ 655 W . E	ess of Facility St. Baltimore				yland 21
		23a. Part 1 Enter the disease, or com	plications that caused	the death. Do not ex						Approximate Interval Betwee
iner iner	Medical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	a consequence of):	(વ.^	2757	nes	\$ ·		
d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. if yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 Fetal death 3	☐ Ectopic pregnan	су		230	d. Date of del Month	ivery Day Yea
ache		Part II. Other significant conditions of	ontributing to death but	t not resulting in the	underlying cause gi	ven in Part I.	23e. Did to	obacco use	contribute to	the cause of deat
e detache	d by						1 🗆 1	res 2	No 3□ Pr	obably 4 🗌 Unk
uld be detache	18	V.							24b. Were au	topsy findings ava
should be detache	1 😤						24a. Was	an ia		
r, page 2 should be detache	Completed						24a. Was autop perfo 1 □ Yes		prior to death?	2 □No
rector, page 2 should be detache	Be	25. Was case referred to medical examiner?	Hospital:		0	hor:	autop perfo 1 □ Yes ath <i>(Check only o</i>	osy rmed? 21 No nne)	prior to death? 1 ☐ Yes	2 🗆 No
ral director, page 2 should be detache	To Be	examiner? 1 ☑ Yes 2 ☐ No		nt 2 ER/Outpatie	SIIL 3 LI DOA	her: 4 \sum Nursing F	autop perfo 1 □ Yes ath <i>(Check only o</i> Home 5 X Resid	osy rmed? 21 No ne) dence 6	prior to death? 1 ☐ Yes ☐ Other (Spe	
funeral director, page 2 should be detache	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Inju	her: 4 Nursing I ury at urk?	autop perfo 1 □ Yes ath <i>(Check only o</i>	osy rmed? 21 No ne) dence 6	prior to death? 1 ☐ Yes ☐ Other (Spe	2 🗆 No
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stely filled in by the funeral director, page 2 should be detache	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only (Check only 2 Medical Examine)	28a. Date of Injur (Month, Day, on the building, etc. 28e. Place of Injur building, etc. 28e. Place of Injur building, etc.	ry 28b. Time Injury ry - At home, farm, so (Specify) of my knowledge, deal examination and/or in the second seco	of 28c. Inju M 1 E	her: 4 Nursing H iry at rk? Yes 2 No	autop perfo 1 □ Yes ath (Check only or Home 5 M Resid 28d. Describe to 28f. Location (so City or Tow e, and due to the	ned? 242 No ne) dence 6 [now injury o Street and f wn, State) cause(s) a	prior to death? 1 Yes Other (Spe	2 □ No cify) ural Route Number s stated.
ompletely filled in by the funeral director, page 2 should be detache	To Be	examiner? 127 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 2 Homicide 29a. Certifier (Check only one) 1 Certifying Property 1 Medical Examined	28a. Place of Injur (Month, Day, building, etc.	ry 28b. Time Injury ry - At home, farm, so (Specify) of my knowledge, deal examination and/or in the second seco	of 28c. Init Wo M 1 [treet, factory, office ath occurred at the investigation, in my	her: A Nursing Nursin	autop perfo 1 □ Yes ath (Check only or Home 5 M Resid 28d. Describe to 28f. Location (so City or Tow e, and due to the	ney 2 No one) dence 6 [now injury of the course of the c	prior to death? 1 Yes Other (Spericcurred	2 □ No cify) ural Route Number s stated. to the cause(s)
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			_	/pe or Print in Black ind State of Maryland / Depa		-		43145
		_	State Registrar	-	tificate of Death	Reg.		T
	Physici	an	Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death
1	/Medic Examin		Barbara E. Uhler 4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Death	December	24, 2010 4c. County of Death	9:39 AM [™]
1	Examini	CI	206 K Chauncer La	· · · · · · · · · · · · · · · · · · ·	Bel Air		Harford	l = =
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth Cou	place (State or Foreign
	Director		220-24-5299 Usual Residence of Decedent	82 Yrs.		March 21,		ryland
	arylan show	'n	10a. State 10b. County	10c. City, Town or Loc Bel Air	cation			10d. Inside City Limits 1 ☐ Yes 2∑ No
	the M	rect	MD Harford 10e. Street and Number	Bel All	10f. Zip Code	10g.	Citizen of What Cou	
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show doat Exantiner must be redified at	Funeral Director	206 K Chaucer Lar	ie	21014		USA	
	er dea items	inne	The Marian Grands	2. Was Decedent Ever in U.S. Armed Forces?	Vas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White,	etc.
036	urs aft		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 🔣 No If Yes, Give 1 Year or Dates:	☐Yes 2X No Specify:		Specify: who	ite
2-0	72 hor	eted	15. Decedent's Educa (Specify only highest grade	completed) (Give	lent's Usual Occupation kind of work done during most of worki		o. Kind of Business/Ir	ndustry
21215-0036	filed within Hygiene. other than '	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+) cle	no NOT use retired)		banking	
nd 2	d 2 should be filed within ? th and Mental Hygiene. 7 is marked other than " traumatic event, the Me	Be C	17. Father's Name (First, Middle, Last)			(First, Middle, Mai		
Maryland	ould by Ment	2	John Magee			ene Hoope		
Mai	nd 2 sh Ilth and 27 is n rtraun		19a. Informant's Name/Relationship (Type Kathleen Phillips		g Address (Street and Number or Rura W. MacPhail Rd;			
ore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be refilled at		20a. Method of Disposition	20b. Place of Dispo			c. Location - City or T	
Baltimore,	tment tant: t		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ② Donation 5 ☐ Other (Specify)	inioval nom state				
Bal	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau <u>once.</u>		21. Signature of Funeral Service Libensee Ronal of B Wa	de prector	Name and Address of Facility Sta 655 W. Baltimore		•	21201
			23a. Part 1. Enter the disease or complic shock, or heart failure. List only one	ations that caused the death. Do not ent			т	Approximate Interval Between
The same	Physician		Immediate Cause (Final disease or condition	Dement	/			Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or on a consequence of)				
760,	te be executed ysician and e burial-transit	calE		Due to (or as a consequence of):				
68	rtificating phy	Medic	IF FEMALE:					
Box	eath certific attending p for use as t	Physician/Medi	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
P.O.	at the de by the tached	hysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	Jotner (specify)			
	de de	by P	Part II. Other significant conditions cont	ributing to death but not resulting in the ur	nderlying cause given in Part I.		cco use contribute to	
of Vital Records,	w requires s been sig should be	Completed				1 Tes		obably 4 Unknown
Re	: The law cate has page 2 :	dmo				24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
/ital	slclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?		26. Place of Deat	1 ☐ Yes 2 ☐ h (Check only one)	No 1 □Yes	2 🗆 100
of \	Physic this cral dire		1 ☐ Yes 2 ☐ No Ho 27. Manner of Death	28a. Date of Injury 28b. Time of		me 5 Residence	ce 6 Other (Spec	cify)
	ding h. After fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injury	Work? M 1 □ Yes 2 □ No	28g. Describe flow	injury occurred	
Division	or Attendater death	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, strubuilding, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
Ω	Hospital o		29a. Certifier 1 Certifying Physi	ician: To the best of my knowledge, deat	n occurred at the time, date and place	and due to the cau	se(s) and manner as	stated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examin one)	er: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, date	e and place, and due	to the cause(s)
_	To the within 2. To the I complet	ž	29b. Signature and title of conffier	4 5	29c. License number	29d	. Date signed (Month	h, Day, Year)
			30. Name and address of person who con	mpleted cause of death (Item 23a) (Type,	Print)		01/06/	2011
_			J- Kevin L	impleted cause of death (Item 23a) (Type,	5 W. MacPhail	Rd. L	Seldir, A	1d. 21014.
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 0 2011	32. Registrar's Signatur	/			
-		æ.	*:::: ×					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ruth Odell Welty December 31 2010 2:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cumberland Golden Living Nursing Center Allegany **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Month, Pay, Y 579-26-4142 1 ☐ M 2**XX**F 84 Months Days Hours 1 Min. 1926 West Virginia Director Feb. Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director MD Allegany Barton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral United States 18903 21521 High 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white If Yes Give 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 ☐ Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any Injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unknown Homemaker Housework Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Odell Brookman မ Julian Lewis 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2645 Cecil Drive, Chester, Maryland 21619 Carol Mowbray/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemeter, crematory or other place)
Cumberland Crematory

01/02/2011 1 Burial 2 Termation 3 Removal from State Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Wage 111 Church St. Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ days disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner laus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year cate has been signed by the a page 2 should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖄 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page performed 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → Wo ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending 1 Yes 2 🔲 No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the pasis of examination allower investigation, initing opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License numbe Court, Churberland, old 2/500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month. Day.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per me,g911,01/28/2011dib Reg. No. for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Lorraine Barnes Wicks 8:20P 30 Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Summerville Assisted Living Westminster 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month Day Year Country) 215-20-8268 84 **Director** 2-2-1926 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Director Westminster MD Carroll 1 🗌 Yes 2 🔀 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21157 119 Winchester Ct. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Supplier Secretary 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Blanche Ward Leslie Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 119 Winchester Ct., Westminster, MD 21157 Edward F. Wicks-husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 1-3-2011 Gamber,MD Providence Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}Fletcher Funeral Home 254 E. Main St. Westminster.MD. 21 21157 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Parkinson's 2 month Physician/ Demaitie Medical Due to (or as a consequence of): 18 miths Examiner embolus Nh Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last CERTIFICATION APPRO Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 9 Unknown 1 ☐ Yes 2 ₪ 9 ☐ Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown tractive 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No HO DVT 24a. Was an autopsy Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in the complete filled 28b. Time of injury **noon**12:00 M 28c. Injury at work?
1 ☐ Yes 2**X** No 27. Manner of Death 28a. Date of injury Certificate: 28d. Describe how injury occurred Natural 5 Pending 06/25/2010 Subject fell Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital 28f. Location (Street and Number or Rural Route Number, City or Town, State) 200 Memorial Ave. Westminster, MD 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 rilas MD D0061558 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER MD 21157 AVE PAKIKM 295 STONER MIGUNI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		Please	Type or Prin				_	_	e.
		ForState	State of Ma	•	epartment o <i>Certificate d</i>	of Health and I		17	0 1011.0
		Registrar 1. Decedent's Name (First, Middle, La	ast)		Cer lincale (Dealli	2. Date of De		3. Time of Death
Physicia		Leatta Ann Bowe					Month Dec	26 20	1:15 PM
/Medical		4a. Facility Name (If not institution, gi	ive street and number)		4b. City, Tow	n, or Location of Death	1	4c. County of	
*		Mallard Ridge Ap 5. Social Security Number 6.		e (In yrs. last birth	Berli		8. Date of Bir	Worces	ster Birthplace <i>(State or Foreign</i>
Funeral Director		,	1 M 2 F 5			ays Hours Min.	Dec 8,	ay, Year) 1956	Country) MD
pu 🖈		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Location				10d. Inside City Limits
Maryla f shor	힏	MD Worcest	er	Berlin					1 ⊠ Yes 2 □ No
r 28a	Funeral Director	10e. Street and Number		<u> </u>	10f. Zip Coo	de		10g. Citizen of Wha	at Country?
th with	ᇛ	Mallard Ridge Ap	ots., #4		2181	1		USA	
er dea	nue	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. Was Decedent If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No o Rican, etc.)	o- 14. Race - Black, \	American Indian, White, etc.
Irs aft	ģ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 □ If Yes, Give Year or Dates:	NO.	1 ☐ Yes 2 🔀	No Specify:		Specify:	African- American
72 hou	eted	15. Decedent's E (Specify only highest gi	Education rade completed)		Decedent's Usual Or (Give kind of work do	ccupation one during most of wor	kina	16b. Kind of Busin	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinations to notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5		life. DO NOT use re	etired)	J	State Moo	dical Facility
filed \ Hygid Sther ent, II	Be Co	17. Father's Name (First, Middle, Las	st)		ALLE	ndant 18. Mother's Nar	ne (First, Middle	, Maiden Surname)	ircar ractificy
uld be Mental rked o	P B	Oscar Lee Davis				Shirle	y Bowen		
2 shour and first ma		19a. Informant's Name/Relationship				reet and Number or Ru			ate, Zîp Code)
1 and Health		Solomon & Patsy 20a. Method of Disposition	Bowen/ & a			son Rd., B	erlin, Date	20c. Location - Ci	ty or Town State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		1 X Burial 2 ☐ Cremation 3 [Disposition (Name of crematory or other		4/2011		
mit. P partme sortan injur:		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		St. Pa	ul's Ceme	ddress of Facility		Berlin,	עוא
permi Depar Impor any ir once.		Jalane 10	7. Walso	}	Lewis N. 1618 Wes	Watson Fu t Rd., Sal	neral Ho isburv,	ome, PA MD 21801	
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused y one cause on each lir	the death. Do n					Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a SND S	STAGE	REN	IAL FA	ILUR	E	3 YRS
Examiner		Toolaning in double,	Due to (or as	a consequence o	f):				
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence o	f):				
executed n and at-transit	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с						
	ш	resulting in death) Last	Due to (or as	a consequence o	f):				
ficate be e physiciar s the buria	dic	•	d						
The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the bur	sician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		2			23d. Date	of delivery
e death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ 10	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal death t time of death	3 ☐ Ectopic pregi 5 ☐ Other (specil			Month	n Day Year
that the dened by the stacked	Phys	9 ☐ Unknown Part II. Other significant conditions		ut not resulting in	the underlying caus	e given in Part I	23e. Did	tobacco use contrib	ute to the cause of death?
ires the signed	þ	PORONIAR M A	RIFRY	Dist	ASF	o givon in raici.		Yes 2 No 3	
w requir s been s should	lete	Di ABOTTEC	METI	TUS			24a. Was		ere autopsy findings available
The law cate has page 2 s	Completed	DINOCICS	1000	103			auto perf	ormed? _ dea	or to completion of cause of ath?]Yes 2 ∐No
sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of De			200 20110
hys this II dii		1 res 2 No			patient 3 DOA			sidence 6 Other	(Specify)
Attending Physician: or death. ector: After this certific by the funeral director, I	tion:	27. Manner of Death 1	28a. Date of Inju (Month, Da	ry 28b. T y, Year) Ir	jury	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurred	
Atten r deatl sctor: by the	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Init	ury - At home, far	m, street, factory, of		28f. Location	(Street and Number	or Rural Route Number,
tal or rs afte al Dire ed in t	Certification: To	4 Hornicide	building, etc					iwn, State)	
	Medical (29a. Certifier 1 Certifying F 2 Medical Example 1 Medical Example	Physician: To the best aminer: On the basis o and manner sta	f examination and	, death occurred at t d/or investigation, in	the time, date and place my opinion, death occ	e, and due to the urred at the time	e cause(s) and man , date and place, an	ner as stated. d due to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier	inh	_	_	cense number	2	29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

3mg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NHU TRAN MD — ACHS TATE

31. Date filed (Month, Day, Year)

JAN 11 2011

32 Registrar's Signature

ACHS TATE

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 8 per fh, g911,01/27/2011dhb
State of Maryland / Department of Health and Mental Hygiene
1- State AMEND#22, perFH, 1/7/11, PMW, MoCo Certificate of Death
Registra AMEND#20bperFH, 1/7/11, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** December 21 2010 1:27 Рм Thomas Joseph Weiss /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 8900 Glenville Road Birthplace (State or Foreign Country) 5. Social Security Number unk 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F 56 Nov 19, 1956 Director Maryland 218-66-6855 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ?7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Examination by mylfing at 1 ☐ Yes 2 ☐ No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 8900 Glenville Road 20901 USA Funeral 12. Was Decedenf Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗓 No Specify Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event. Item Elementary/Secondary (0-12) College (1-4or 5+) 12 0 union carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Thomas Weiss Jr Anita Mullane ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Weiss/sister 10854 Whiterim Drive Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other (Specify) in state Chesapeake Crematory 1-7-2011 22 Name and Address of Facility H. Bacon Fineral Home Inc. 21. Signature of Euneral Service Licensee Ronald S. Wade, 14th Street of W. Washington, D.C. Director 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1aketes **Physician** 2206 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed Exami burial-trar Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 8 in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No the detached 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 ☑ No Hospital or Attending Physiclan: 24 hours after death.
Funeral Director: After this certifice 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No npletely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation NIA 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C
completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Dempsey, M.D. 3200 Tower Oaks Blvd; Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 07 201 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Physician/ Month Monica Wilson Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death North East 134 Bethel Springs Drive Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In yrs. last birthday) 1 - M 2 - F Days (Month, Day, Year) 198-58-0659 50 Yrs. Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Directo MD Cecil North East 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 134 Bethel Springs Drive 21901 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Completed by 1 Never Married 2 X Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XXNo Specify: 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 lith and Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Brokerage/Insurance Co. 12 Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Pauline Damiano Frank Palma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Peter Wilson 134 Bethel Springs Dr., North East, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Delaware Co. Crematory 1-12-2011 Lansdowne. PA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Enter the dise ck, or heart failure List Immediate Cause (Final Physician/ LUNG Chhier disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed red by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, the Hospital or Attending Physician: The law requires Completed autopsy performed certificate Yes 2 Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 1 Yes 2 🖪 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA in 24 hours after death.

he Funeral Director: After this pleted filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified

15 Rajafame M.D. DOOS 7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSRAJAPAKR, M.O. 2835.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 🗌 Yes 2 🕱 No

Year

2010

14. Race - American Indian,

Specify: White

Cecil

22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryla Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Other (Specify, 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 1/12/11 2835 Sm. Pi N. 5-203, Baltimore, MO. 21209 32. Registrar's Signature **ORIGINAL**

Registrar

31. Date filed (Month, Day, Year)

JAN 25 201

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 13 Physician/ 2010 4:20 Ам Susan Wylie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care - Sandtown Baltimore 8. Date of Birth July 25, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk 7. Age (In yrs. last birthday **Funeral** Days Hours Months 1 M 2 X F 91 226-30-0355 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗗 Yes 2 ☐ No Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 1100 Pennsylvania Avenue Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? U Black, White, etc. ş 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after Specify: black 1 Yes 2X No Specify: Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation UN (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry un (Specify only highest grade completed, should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a 10 N. Calvert St. Ste 200; Baltimore, MD 21202 Freida A. Jones - guardian Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in State 22. Name and Address of Facility State Anatomy Roard 21. Sign turn of Funeral Service Licenses Di 655 W. Baltimore St; Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each line. Immediate Cause (Final Vascular Derenha Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical of or Attending Physicians: The law requires that the death certificate be after death.

Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 nknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 읻 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Matural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Caymord Much Da7683

State Registrar 31. Date filed Worth

Smite 203

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Balhmeri

2120 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Smith

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician/ WARREN WALLACE P^{M} DECEMBER 2010 Medical 4b. City, Town, or Location of Death CHEVERLY 4a. Facility Name (if not institution, give street and number)
PRINCE GEORGE'S HOSPITAL 4c. County of Death PRINCE GEORGE'S Examiner Date of bits. (Month, Day, Yea If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sev 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 X M 2 □ F 83^{Yrs.} Director WASHINGTON, DC 577-32-1029 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD UPPER MARLBORO PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20774 13501 MESSENGER PLACE death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 2 NoNAVY þ 1 Never Married 2 Married 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No SpecifyBLACK "natural", 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) EMISSION INSPECTOR 12TH GOVERNMENT Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BURNETTA SPRIGGS ၉ LEROY WALLACE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13501 MESSENGER PLACE UPPER MARLBORO, MARYLAND 20774 WALLACE/WIFE BARBRA 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Dispositi X Parial 2 Cremation 3 Bemoval from State APLINGTON CEMETERY 2/18/11 ARLINGTON, VIRGINIA Donation 5 D Other (Sp 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service ensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on said Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine ysician and le burial-trans that initiated events resulting in death) Last Physician/Medical requires that the death certificate be P.O. Box 68760 attending physi for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No the 9 Unknown g Unknown is been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Division of Vital Records, 1 Tes Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law in 24 hours after death.

In 24 hours after death.

Euneral Director: After this certificate has been pletted filled in by the funeral director, page 2 s autopsy performed' 1 ☐ Yes 2X ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🕽 1 Tes No ဂ္ Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? Accident Investigation 6 Could not be Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2
To the I
comple only one) 29b. Signature and title of certifier 29c. License number 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEMÉTROIS J. CATEVENIS M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 (Month, Day, Year) 32. Registrar's Signature State JAN 20 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Day 31, Physician/ Lawrence Amman December 2010 10:33 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 10860 Bucknell Drive. Silver Spring If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Michigan (Month, Day, Year) av 18, 1946 1 X M 2 🗆 Months Days Hours Min. Director May 370-50-4128 64 Usual Residence of Decedent show 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No MD Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10860 Bucknell Drive, #201 20902 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian, 11. Marital Status Armed Forces? Black White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1967-70 1 ☐ Yes 2 XXIo Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Educational Tour Guide Travel other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H is marked of မ Albert Amman Margaret Cain permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10860 Bucknell Drive, #201, Silver Spring, MD 20902 Mary Robitaille/Wife 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 🛛 Cremation 3 D Removal from State Jan. Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) 2011 Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 1503 110 500 University Blvd. Spring W., MD 23a. Roy 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Cancer of Unknown Primary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine it any leading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to jor as a consequence of il or Attending Physician: The law requires that the death certificate be executed after death.

Director; After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death ☐ Yes
☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes Other: 2 😾 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending Accident 1 Yes 2 No Investigation npleted filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Shuchi

Shuchi Saluja, MD

31. Date filed (Month, Day, Year)

JAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

MO 32307

6900 Georgia Avenue, NW, Washington, DC 20307

1-4-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 02^{Day} 2010^{Year} Physician/ Mona Lisa Month 12 Blyther 8:55 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton PG Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 5 F Months Days Hours Min. 12-20-1958 Washington, 579-84-9344 Director 51 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No MD PG Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7420 Marlboro Pike 20747 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Cashier M cDonalds Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Archie Blyther Cobb Rossie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Lee Blyther 3558 Dean Drive#K5, Hyattsville, Md, 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Chesapeake Crematory 12-09-10 1 Burial 2 X Cremation 3 Removal from State Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Wash. DC 21. Signature of Funeral Service Licens 22. Name and Address of Facility Dunn & Son Funeral Home, 5635 #ads st. NE 20019 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death with Kespirohe Ph_sician/ meunoug Bilatera disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature of certifier 29d. Date signed (Month, Day, Year) 1)0055120 Dec 3rd 2010 Mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 southern avenue SE Soute 310 Washington DC Richard Palmer mid 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 1 2011 arke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		FOI	ertificate of Death	Reg. No.		
Physic	ian/	1. Decedent's Name (First, Middle, Last) Robert E. Belt		2. Date of Death Anoth Day Year	3. Time of Death 1:10p M	
Med Exam	dical iner	4a. Facility Name (if not institution, give street and number) 5500 Burrell Court	4b. City, Town, or Location of Death	December 30, 203 4c. County of De Prince G	eath	
Funera Directo		5. Social Security Number 5. Social Security Number 5. Sex 1 ▼ M 2 □ F 7. Age (In yrs. last birthday, 94 yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 10, 1916	Birthplace (State or Foreign Country) ashington DC	
laryland 3a-f show iffied at	ector	Usual Residence of Decedent	ocation Silver Spring		10d. Inside City Limits 1 A Yes 2 □ No	
with the M s 23a or 28 ust be not	Funeral Director	10e. Street and Number 2828 Blue Spruce Lane	10f. Zip Code 20906	10g. Citizen of What (•	
perfull (1996) INIGITY I STATES AND CONTROL OF THE MATEUR	ed by Fur	1 Never Married 2 Married 1 Never Married 1 Ne	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	A	nerican Indian, nite, etc. frican merican	
rithin 72 hou iene.	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv. life. Elementary/Seconday (0-12) College (1-4 or 5+) 16c. Dec (Giv. life. life.	edent's Usual Occupation a kind of work done during most of work DO NOT use retired) Educator	ing 16b. Kind of Busines	·	
yiand a lid be filed w Mental Hyg narked othe	To Be			ne (First, Middle, Maiden Surname) E. Moulton		
, Mary nd 2 should saith and N n 27 is ma er trauma		1 5 11 - 1 7 5 1 5 7 / 16 1	ling Address (Street and Number or Run 28 Blue Spruce Lane			
Page 1 and ment of Heatant if item ury or other		4 Donation 5 Other (Specify)	ematory or other place) Memorial 1/05	Date 20c. Location - City Rockville,	Maryland	
Depart Import any inj	ouce		22. Name and Address of Facility M C 7400 Georgia Avenu			
Physician Medica Examine	al er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events	ter the mode of dying, soon as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical Examiner	III FEMALE:	Other (specify)	23d. Date of o Month	Day Year	
equires that the			underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3		
The law requires cate has been signage 2 should b	Completed			autopsy prior to performed? death	autopsy findings available o completion of cause of ? /es 2 No	
onling Physician: anding Physician: sath. br: After this certific he funeral director,	Certificate: To Be	25. Was case referred to medical examiner? 1	T Training 11	ck only one) Other (Specify) Assisted		
tal or Attendir us after death. ral Director: Af			- 80	28f. Location (Street and Number or F City or Town, State)		
o the Hosp rithin 24 hou o the Funer ompleted fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or inversional one) 2 Medical Examiner: On the basis of examination and/or inversional one of the basis of examination and or inversional one of the basis of examination and or inversional one of the basis of examination and or inversional one of the basis of examination and or inversional one of the basis of examination and or inversional one of the basis of the basis of examination and or inversional one of the basis of the basis of examination and or inversional or	estigation, in my opinion, death occurred a	at the time, date and place, and due to th	e cause(s) and manner stated. as stated.	
「ヤヤ		30. Name and address of person who completed cause of death (Item 23a) (Type,	D0070102			
	tate		1 Court, Largo	MD 20774		
Regis		1AN 07 2011 / / //	12			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ December 2010 8:10 A <u>Dayananda Brahmana</u>nayake 30, Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Casey House 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Numb **Funeral** (Month, Day, Yea Hours Sri Lanka Months Days 1 **X**M 2 □ F 213-63-8933 1944 Director 66 Usual Residence of Decedent 10d. Inside City Limits Show 10c. City, Town or Location 10b. County 10a. State within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 X No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States Funeral 20852 199 Rollins Avenue #804 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Narried þ Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2 X No Specify: If Yes Give Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Sales 0 Cashier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental [§] Important: If item 27 is marked o Unknown Unknown other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9a. Informant's Name/Relationship (Type, Print) spouse Chandrika Brahmananayake, 199 Rollins Avenue #804, Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State ō Fort Lincoln Crematory 1/3/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) any injury 22. Name and Address of Facility **Simple Center** Tribute Funeral & Cremation 21. Signature of Funeral Service Licenses MOILD Rockville, Maryland 20852 KOI Pike, 1040 Rockville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani year disease or condition resulting in death) Hepatocellular carcinoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Month Day Year in the past 12 months? Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown Division of Vital Records, Completed should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s has performed? Yes 2 No 1 ☐ Yes 2 🛣 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) Hospice 1 Yes 2 **X** No ပ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury X Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation ☐ Accident ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Tpleted 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 -- 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Maryland 20850 1355 Piccard Drive, Suite 100, Geoffrey Coleman,

State

Registrar

31. Date filed (Month, Day, Year)

JAN 05

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Z 5 th Year Month Day Physician/ December 8:03 AM Elmer Blaine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Prince George Hospital Cheverly If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral 1 XM 2 - F Months 05/06/ Country) Director 229-12-1337 85 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Health and Mental Hygiene. Bant: If item 27 is marked other than "natural", or items 23a or 28a-f show than the Item with the Medical Examiner must be notified at jury or orther traunatic event, the Medical Examiner must be notified at 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Director Yes 2 ☐ No Prince George Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 500 N Harry Turman Drive USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private & P Telephone Co 12vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sam Blaine Roberta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON Tyrone Blaine 18th Pl SE Washington, DC 20020 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Durial 2 Cremation 3 Removal from State 01/08/11 Riverdale, Md 4 Donation 5 Other (Specify) Riverdale Park 21. Signature of Funeral Service Licensee The allows of Posty Williams Funeral & Cremation ame E Willem mo 1182 5732 Georgia Ave NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cardiopulmonary Collapse disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CARDIAL Sequentially list conditions than, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events this certificate has been signed by the attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-fragati -schemic Vears Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by Fluid Overload 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 XNo Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 🗽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 30th D52865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Amapolis

Road

Suite

200

12150

32. Registrar's Signature

Dale

Glenn

MD 20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2010 December 2:06 Harold Cenney /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Director January 26,1964 Germany 212-92-6979 46 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show traumatic event, the Medical Evanimer hust be notified at 1 ☐ Yes 2√☐ No Director Maryland 01ney Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 23a or 3202 Spartan Road #7 20832 United States Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 72 hours after 1 ☐Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2X No altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than 'n any Injury or other traumatic event, Italia Elementary/Secondary (0-12) College (1-4or 5+) Medicine Hospital Stock Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harold John Cenney Edith Ingrid Huhne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laura Ferrenz Cenney, spouse 8202 Spartan Road #7, 01ney, Maryland 2083220b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory: 1/11/2011 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician**) ME disease or condition resulting in death) /Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending Self-Inflicted 2030 M 1 ☐ Yes 2 No 24 hours after death.

Funeral Director: A investigation 2 Accident Dec 12 2010 6 Could not be determined 28f. Location (Street and Number of Rural Route Number, City or Town, State) 3 2 0 2 Spart Con RN 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Homo | CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2

State

completely

within 2

Medical

29a. Certifier

(Check only one)

Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 05

Box 68760.

P.0.

Records.

Division of Vital

Registrar

DHMH 17 Rev 1/2001

moome

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

mo

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health State Registra/MEND#24a/bperMD, 1/10/11, BW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 8:39 A. M Physician/ Armand N. Chrapaty 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 1011 Arcola Ave Wheaton 5 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sev 7. Age (In vrs. last birthday) **Funeral** Days Min. 1 🙀 M 2 🗆 F Hours 183-10-9074 Yrs Director 97 France May 10 1913 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State the Medical Examiner must be notified at 10d. Inside City Limits Director MD Montgomery Wheaton 1 🛛 Yes 2 🗆 No 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ŏ Funeral 23a 1011 Arcola Ave 20902 USA "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give WW II
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 3attimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify: 3 Widowed 4 ☐ Divorced Completed White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Dry Cleaning Sundries injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Isaac Chrapaty Rose Chrapaty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Ilona Chrapaty/daughter 1612 Montague St, NW, Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State George Washington 4 ☑ Donation 5 ☐ Other (Specify) Dec 23, 2010 Washington, DC University Medicales CFacility uneral Service License Stanature of Columbia Mortuary Service PA, 9013 Annapolis Rd, Lanham, MD 20706 /M00969 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the burial-transit Cause (Disease or iinjury that initiated events law requires that the death certificate be executed 0 Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 🗌 No ed by the detached f g Unknown g Unknown P.O. signed i Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No has page or Attending Physician: The 1 ☐ Yes 💥 No 26. Place of Death (Check only one) of Vital the funeral director, 25. Was case referred to medical Be examiner? Hospital Other: 1 Tes 2 No ပ္ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural To the Hospital or Attending within 24 hours after death.

L. To the Funeral Director: After completed filled in by the fun 5 Pending Division 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number ned (Month, Day, Year) 6 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1081 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = Registrar amend 26 per hosp, 20 per f Gertigo to 020 4711 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GABRIEL MICHAEL DIETRICH OCT 2010 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY Social Security Number 8. Date of Birth (Month, Day, Year)
Oct. 26, 2010 6. Sex 1 ፟ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Hours Country) Maryland Director Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Medical Examiner must be notified at Director 1 🗆 Yes 2 🖾 No Dale City Prince William VA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 23a Funeral 22193 14911 Daytona Court USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 1 Yes 2 No by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the None Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked o ၉ Valerie Rebecca Dietrich Jiquon Dominique Sitton permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie R. Dietrich - Mother 14911 Daytona Ct., Dale City, VA 22193 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place. 11/19/10 Alexandria, VA 4 Donation 5 Other (Specify) Metropolitan Crematory 21. Sign ture of Funeral Service Licenses 22. Name and Address of Facility Found & Sons Lee Funeral Chapel 8521 Sudley Road, Manassas, VA 20109 Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shook, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) EXTREME PREMATURITY Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death Month Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s performed? certificate 1 Yes 2 No Yes 2 x No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 1 X No Other: 1 A Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifie 29c. License number

State Registrar DHMH 17 Rev 7/2009 HALI

BRIAN H

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09713/2010 Fortson III Elbert Speed Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince Georges Prince Georges Hospital Cheverly If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 19 15 7 1 1954 55 Director unknown Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Temple Hills 1 🔀 Yes 2 🗌 No MD Prince Georges ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be 3226 Burton Court Funeral 20748 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify: If Yes, Give Year or Dates 3 - Widowed 4 - Divorced Completed I Hygiene. other than "natur. vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life DO NOT use retired)
Construction Supervisor Elementary/Seconday (0-12) College (1-4 or 5+) Eastern Waterproofing should be filed with and Mental Hygier I is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. ည Elbert Speed Fortson II Dorothy Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co e) Elbert Fortson IV/ Dateleaf Ave. Seat Pleasant MD 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State emetery, crematory or other place) Riverdale Crem. 09/22/2010 Riverdale MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20019 Dunn&Sons 5635 Eads St. NE Washington,DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or a asequence of I or Attending Physician: The law requires that the death certificate be executed after death.
Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 1 of Vital 25. Was case referred to medical director, Certificate: To Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes Other: 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manne#of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injurv 5 Pending Division 1 🗆 Yes 2 🗌 No Accident Suicide investigation Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours a within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Napre and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State FEB 0 9 2011 Registrar

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aminer	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death	
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n n		Mailing Address (Street and Number or F	Tural Route Number	r, City or Town, State, Zi	o Code)
r tra	Pauline White/Mother PO	Box 1761, Parks	lev, VA	23421	
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and	Maria,	Bennie Smith S	alisbur	y, MD 218	01
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completely filled in by the fu Medical Certification		29c, License number		29d. Date signed (Month)	Day, Year)
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	30. Name and address of parson who completed source of death (Hear CO). (7)	ima Print)		1/0/11	
	30. Name and address of person who completed cause of death (Item 23a) (1) Sandra Marshall and Bauthmere VA	29c. License number D0035363 ype, Print) Medical Center 10 N	Greene S	t. Baltmore	MD2(201
State	31. Date filed (Month, Day, Year) 32. Registrar's fignature	N. S			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:10 AM 0 31 2010 ram Medical 4a. Facility Name (# not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 2300 Dexter Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🛛 M 2 🗆 Days Hours Min Month, Day, Year) 37 579-50-8267 Washinaton. **Director** 73 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important, if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 U.S.A. 2300 Dexter Avenue 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married ^{2 □} № Korean 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 🗆 Widowed 4 🗆 Divorced Year or Dates Conflict 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical U.S. Government Vesigner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Irene Vivian White Floyd Hiram Hunsaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2300 Dexter Avenue, Silver Spring, Maryland 20902 Patricia Hunsaker - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 L Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 01/05/2011 Silver Spring, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Vel 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer of Bladder disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) tending physician and or use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the inneal director, page 2 should be detached for use as the burlat-ligansit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 뎯 Other: 1 🗌 Yes 2 🛛 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0003792 January 06, 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

Irnest S. Oser,

31. Date filed (Month, Day, Year)

M.D.,

32. Registrar's Signature

10301 Georgia Avenue, #304, Silver Spring, Maryland 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 330 M **Physician** DECEMBER Joshua Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTI MORE
If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number AUNES 8. Date of Birth (Month, Day, 11 12 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) Hours Months Days 1 XM 2 □ F 26 SC Director 84 250-38-5949 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ar must be notified at 1X Yes 2 □ No Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō U.S.A. 21215 3000 Towanda Ave #314 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status Black White etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 event, the Medical Exami 1 ☐ Yes 2 ☐ No Black Specify: Specify: \$ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) George P. Garrett 8th grade na Inspector marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Johnson Caroline Jero ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sh Health and tem 27 is n 3000 Towanda Ave #314, Baltimore, Md 21215 Lula Johnson-Wife permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 12/29/2010 Baltimore, Md Loudon Park 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service Licensee 22. Name and Address of Facility The West Md 21215 Baltimore, 4300 Wabash Ave, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASPIRATION Sequentially list conditions, Due to for as a consecuence off Examine if any, reading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-transit STROKE Due to (or as a consequence of): 68760 Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à HYPERTENSION 2 200 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 → funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 → Impatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending Matural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 29a. Certifier 🕊 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

OLIVEIRA

FEB 0 2 2011

DHMH 17 Rev 1/2001

person who completed cause of death (Item 23a) (Type, Print)

10-10117 Valerie Kapitan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

valerie Kapitari	1- For State Registrar	ate of Maryland /	-	te of Death	iu ivientai n		g. No. 2011	0 43165
Physician/ Medical Examiner	Decedent's Name (First, Middle Decedent's Name (First, Middle	_{e,Last)} Kapitan				2. Date of Deat Month December		3. Time of Death 1421 hrs
	4a. Facility Name (if not institution				r Location of Death		4c. County of D	Death
Funeral	1220 Sledge Way 5. Social Security Number	6. Sex 7. Age	e (In yrs. last birtho	Saint Leon		s. 8. Date of Birt	Calvert	Birthplace (State or
Director	046-42-6124		50	Yrs. Months Day		_		oreigrConnecticu Country)
any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			_	10d. Inside City Limits
and show a	MD Cal	vert	Saint Le	eonard				1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 1220 Sledge	Way		10f. Zip Code 2068	35	10	g. Citizen of What USA	Country?
r death with or items 23s const be not	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces?		13. Was Decedent of Hi If Yes, specify Cuba			14. Race - A White, e	merican Indian, Black, tc.
after de la	3 Widowed 4 Div	orced if Yes, Give Year or Dates:	X No	1 Yes 2 X No	o s <i>pecify:</i>		Specify:	White
hours Exami	15. Decedent's Education (Spec Elementary/Secondary (0-12)	cify only highest grade com	du	ecedent's Usual Occupa iring most of working life			16b. Kind of Busin	ess/Industry
5-0036 fled within 72 hours after Hygiene. to ther than "natural" the Medical Examine Completed by	Liomentally/decordary (0-12)	2		Financial D	irector		Public H	Research
215-0 be filed w ntal Hygin riked othe ent, the l	17. Father's Name (First, Middle, Joseph Kalino				18. Mother's Name	(First, Middle, M tta Gole	·	
D 2121 Should be fi marked aftic event, To Be	19a. Informant's Name/Relations		707	Mailing Address (Stre				
e, MD and 2 sho Health and item 27 is traumati	Frank Kapitan 20a. Method of Disposition		20b. Place of I	40 Chatham Disposition (Name of ce	emetery,	Date	MD 2140. 20c. Location - Cit	
MOF Pages I tent of I int: If	1 Burial 2 X Cremation 4 Donation 5 Other Sp			y or other place) Crematory,	INC.	uary 11, 2011	Baltimon	ce, MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other residuals.	21. Signature of Funeral Service			22. Name and Addres CREMATION 495 Ritch	of Facility DIRECT	Severn	a Park, N	AD 21146
Physician	23a. Part 1. Enter the disease, or failure. List only one cause		he death. Do not e					Approximate Interval Between Onset and
Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Oxycodo:	ne Intox:	ication				Death
	Sequentially list conditions,	b						
nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consec	quence of):					
d ansit	events resulting in death) Last	Due to (or as a consect	quence of):					
60, ate be executed hysician and e burial - transit Medical Examiner	★ UNPENDED		3a,27,28a	a-f per me	g912 2-9	-11 vt		
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outcom	e of pregnancy	Fetal death 3	Ectopic pregna	ancy	23d. Date of del Month	ivery Day Year
h. Box 687 the death certification by the attending placed for use as the Physician/I	past 12 months? 1 Yes 2 No 9 ✔ Unk	4 Pregnant at t		Other (Specify)				
b.O. Bathat the defeate by the detached f	Part II. Other significant conditi	3 Officiowit	but not resulting in	n the underlying cause	given in Part I.	23e. Did tol	pacco use contribute	e to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral Greecor, page 2 should be detacted in the funeral or To Be Completed by P							2 ✔ No 3	
Records, The law requires froate has been sig , page 2 should be Completed						24a. Was a autops	y prior	e autopsy findings available to completion of cause of h?
Vital Recc ysician: The la his certificate ha director, page 2	25. Was case referred to medical	1		26 Place	e of Death (Check	1 ✓ Yes 2		Yes 2 No
f Vital Physician or this cert ral director	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatien	t 2 ER/Outp	patient 3 DOA	Other		Residence 6 🗸 C	ther: Scene
n of \ding Ph; h. After tl funeral	27. Manner of Death 1 Natural 5 Pend	28a. Date of Injur (Month, Day,Ye	ar)		ry at Work? Yes 2 k No	28d. Describe h	ow injury occurred	
Division o spital or Attending hours after death, hearal Direct cart, filled in by the fune Certification:	2 Accident Inves	tigation 10 12-30	D-10 fd 1 ury - At home, farm	street, factory, office t		unknown 28f. Location (Si		Rural Route Number, City
Div ppital o cours aft filled in	4 Homicide deter	and the second second	ouse			St. Leo	nard, Md	Rural Route Number, City Ledge Way
To the Hospita within 24 hours To the Funcarial completely fille	(on our or my	ysician: To the best of my niner:On the basis of exam	-					
To with To con	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
	Maryante	mellinel		O.C.	M.E.		December 31	, 2010
VCH	30. Name and address of person Margarita Korell MD.	who completed cause of de Assistant Medical E	,	00 W. Baltimore S	treet, Baltimoi	e, MD 21223		
State	31. Date filed (Month Day, Year)		s Signature	backer				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of M	aryland / Der <i>Ce</i>	partment of I			giene leg. N6) () ()	13166
			Registrar 1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea		3. Time of Death
п	Physicia	_	Alexander Klige					Decembe	er 31, 2010	630 PM ^M
and a	/Medic Examin		4a. Facility Name (If not institution, give		1	4b. City, Town, o	or Location of Dea	ath	4c. County of Dea	th
	Examin	-	Wilson Health Ca	re		Gaithe			Montgome	
	Funeral		5. Social Security Number 6. S		ge (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hr Hours Mir	(Month, Day	v. Year) C	thplace (State or Foreign ountry)
	Director		13-07-8844	9:	1 Yrs.			March .	16, 1919	New York
	pur »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits
9	f sho	ō	MD Montgom	ery	Gaithersb	urg				1 La Yes 2 La No
^	the N	Funeral Director	10e, Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
1	with	Ö	221 Booth Street	Apt 220			20878		United :	States
/	ms 2	Jer?	11. Marital Status	12. Was Decedent	Ever in U.S.	B. Was Decedent of If Yes, specify Cub	Hispanic Origin?	(Specify Yes or No-	14. Race - Am Black, Whi	
9	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯 If Yes, Give	No	1 ☐ Yes 2 ☐ XNo		sito incari, etc./		White
903	72 hours after death with the Maryland 'natural", or items 23a or 28a-f show digal Exeminal must be nutified at	d by	3 ₩ Widowed 4 □ Divorced	Year or Dates:						
21215-0036	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Gi	pedent's Usual Occu ve kind of work done v. DO NOT use retire	during most of w	vorking	16b. Kind of Business	ringustry
121	vithin sne. than	du	Elementary/Secondary (0-12)	College (1-4or	5+)	inancial		7.0	Finance	
2	Hygie Hygie Iher	ပ္သို	17. Father's Name (First, Middle, Last,	<u> </u>		Inancial		ame (First, Middle,		
Maryland	d be featal red or c eve	o Be	David Kliger				Sadie 2	Zelikow		
Z	should mark matis	ဥ	19a. Informant's Name/Relationship	Type. Print)	19b. Ma	iling Address (Stree			er, City or Town, State,	Zip Code)
\mathbf{E}	nd 2 selfth an 27 is 27 is r trau	1	Susan Streufert -	daughter	15	208 Grave	enhurst '	Terrace N	orth Potom	ac MD 20878
ē,	s 1 al if Hez item othe	1 8	20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pla	ace)	Date	20c. Location - City of	r Town, State
Ë	Page nent c nrt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	☐Removal from State (y)		Cremato		/05/2011	Falls Chur	ch, VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the "actival Executor in an exact or natified at once.		21. Signature of Funeral Service Inc.	TSUE .	01163	22. Name and Addi Edward Sag 1091 Rock	ess of Facility	ral Direc	tion Inc 20	852
	An Inch	-	23a. Part 1. Enter the disease, or com	plications that cause	ed the death. Do not					Approximate Interval Between
	Physician	7	shock, or heart failure. List only Immediate Cause (Final		_{ine.} Spiration	Pneumonia	a			Onset and Death
	/Medical		disease or condition resulting in death)	, d	s a consequence of):	1 II Camoni	*			
	Examiner			b C	erebrovas	cular Acc:	ident			
	B = 0	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•	s a consequence of):					
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	U	lypertensi	on				
8760,	oe execian a	ũ	resulting in death) Last	Due to (or as	s a consequence of):					
87	icate l physic the b	dical		d						
9 x	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Med	IF FEMALE:	23c. if yes, outcome	e of pregnancy				23d, Date of o	eliverv
Box	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)			Month	Day Year
O.	the d	ysi	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown						
σ.	ires that the de signed by the be detached f	4	Part il. Other significant conditions	contributing to death	but not resulting in th	e underlying cause g	iven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
rds	requires leen sign nould be	d by						_ 1□`	Yes 2∐XNo 3∐	Probably 4 ☐ Unknown
of Vital Records,	_ 0 70	Completed						24a. Was		autopsy findings available o completion of cause of
Re	The law cate has page 2 s	mo						autoj perfo 1 ∐Yes	rmed? death	es 2 🗆 No
ta	ician: The certificate ector, pag	a	25. Was case referred to medical				26. Place of I	Death (Check only o	_	
>	Physician: this certific ral director, I	o.	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpat	tient 2 🗆 ER/Outpa	tient 3 DOA	ther: 🏻 Nursin	g Home 5 ☐ Resi	dence 6 ☐Other (S	pecify)
0	ding Ph h. After th funeral	٦	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of In (Month, D	ijury 28b. Tim Day, Year) Inju		jury at ork?	28d. Describe	how injury occurred	
<u>0</u>	ending sath. or: After he funer	äţi	2 ☐ Accident investigation				∐Yes 2 □ No			
Division	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	28e. Place of Ir building, e	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office	9	28f. Location (City or To	Street and Number or wn, State)	Rurai Houte Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Completely filled in by the fu	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the bes miner: On the basis and manners	of examination and/o	eath occurred at the r investigation, in m	time, date and p y opinion, death o	lace, and due to the occurred at the time	e cause(s) and mannel , date and place, and c	as stated. lue to the cause(s)
	To the within 2 To the Comple	Mec	29b. Signature and title of certifier	and mainter		29c. Lice	nse number		29d. Date signed (Mo	onth, Day, Year)
	H 5 H 0		A. Seid	lman	J. mis	D378	01		12/31/20	10
			30. Name and address of person who	completed cause of	death (Item 23a) (Ty	pe, Print)	#300 B-	okvilla N	vm 20850	
			Aimee Jane Seidm		20 Shady G	tove koad	. #300 KC	CKVIIIE I	20070 س	
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 0 7 201		A A	Was Co				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state
RegistraMFND#23a-I + ITperMD, 1/7/11, BM, Mo Sertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Pricilliano Lampa Lugue December 29, 7:40 am 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 1904 Oliver Street Huattsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours 578-82-6116 Director 78 Philippines 01/04/1932 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d, Inside City Limits 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Motical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1904 Oliver Street 20782 U.S.A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 🗓 No þ Specify: Specify 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Dishwasher Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental ant: If item 27 is marked o Daniel Lugue Perpetua Lampa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1904 Oliver Street, Hyattsville, Maryland 20782 Editha Lugue - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State pomit. Pages 1 Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 101/04/2011 Silver Spring, MD 5 ☐ Other (Specify) re of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signatu 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acture -- end stage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to inimical decause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cardiovascular Atherosclerotic Disease and signed by the attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Diabetes Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 □Yes 2 😧 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 😿 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only

Division of Vital Records, P.O. Box 68760, 24 hours after death Funeral Director; To the

> State Registra

29b. Signature and title of certifier

Martin Weltz. 31. Date filed (Month, Day, Year)

JAN 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

8724 Jericho City Drive, Landover, Maryland

D23743

29d. Date signed (Month, Day, Year)

December 30. 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 1/12/11, M.S. Kent Co. Amended#7 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SHIRLEY S. SHAHAN MOFFETT DECEMBER 2010 6:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death OCEAN CITY WORCHESTER 127 SOUTH OCEAN DRIVE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 08/04/1932 **Director** MARYLAND 220-28-4580 68 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No WORCHESTER OCEAN CITY 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 127 SOUTH OCEAN DRIVE 21842 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner and once. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify 3 X Widowed 4 □ Divorced Completed Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 SEAMSTRESS TEXTILE Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked ot CHARLES B. STEVENS CATHERINE V. BENTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30360 CODS POINT ROAD TRAPPE, MARYLAND 21673 JEFF SHAHAN / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WESLEY CHAPEL CEMETERY 01/02/2011 ROCK HALL, MARYLAND 000 Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND Bud & 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Carcinauca Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No 1 Yes 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Gertifying Nurse Practioner: To the best of my knowledge, deeth or 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ame and address of person who completed cause of death (Item 23a) (Type, Print) Weder Doro dulla Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#11perFH, 1/7/11, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Maletta Month Gregory David 2010 Magnon December 2:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9707 Old Georgetown Rd #106 Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Bitts | Min. | Months | Days | Hours | Min. | March | 123, 1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 □ F 023-16-4008 98 Italy Director Yrs Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f MD 1 Yes 2 No Montgomery Bethesda ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9707 Old Georgetown Rd #106 20817 United States Was Decedent Ever in U.S.

Armed Forces?

13. Was Decedent of Hispanic Origin? (Specify Yes or NoArmed Forces?

14. Yes, Sive - 1, 1943 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. ral", or iten Examiner ģ 1 Never Married 2X Married within 72 hours after If Yes, Give Year or Dates. Dec 7,1945 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify:White If Yes, Give "natural" Completed 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Clergy Episcopal Church Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental I ျှ Lorenzo Maletta Anna Maletta traumatic Magnone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Maletta/Son 2800 36th St., N.W. Washington DC 20007 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State National Crematory 12/24/2010 4 Donation 5 Other (Specify) Falls Church, VA Signature of Funeral Service Lieensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Alzheimer's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Undership Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? Month Day Year 1 Yes 2 No à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 s autopsy performed? Yes 2X N certificate **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital Other: ${}_4 \square$ Nursing Home ${}_5 X$ Residence ${}_6 \square$ Other (Specify) 1 🗌 Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director, After 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sile 10 D55258 Dec 22,2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7758 Wisconsin Ave, #211 Bethesda, MD 20814 Dr. Garv Wilks 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JAN 07 2011

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar MFND#25perCRNP_1/5/11_FMW_McCo Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12/24/2010 М JEAN DORIS SMITH MAHONE 5:05 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Casev House Rockville Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🛣 F Days Min. 11/19/1935 Director 214-32-9642 75 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 □ No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 18539 Split Rock Lane 20874 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 X No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Student Hall Monitor Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alfred Smith Dorothy Virginia Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Bonnie J. Jackson/daughter 18539 Split Rock Lane, Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemerely, crematory or other place) 1 XBurial 2 Cremation 3 Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Pk 01/03/11 Rockville, MD 21. Signatur of Funeral Service Lic 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one tions that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cor pulmonale disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or finjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonary Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? CVA 24a. Was an autopsy ☐ Yes 2 🔯 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2**X** No ျ 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending injury ☐ Accident Investigation 6 Could not be 28e. Place of Injurý - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi

State

Registrar

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Deborah Miller, CRNP

JAN 05

31. Date filed (Month, Day, Year)

29c. License number

6001 Muncaster Mill Road, Rockville, MD 20855

R143201

29d. Date signed (Month, Day, Year)

12/24/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrary MFND#19bperFH, 1/19/11BMW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ Ernest Lee Parker, Jr. lecember . 11:30 am HOTO 26 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Prince Georges Lanham Doctors Community Hospiat Social Security Number Age (In yrs. last birthday) If Under_1_Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Ye) ec. 3, 578-74-3645 1XXM 2 | F Months Hours Director 1956 Washington DC Dec. Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examinar mant has maded in 1. 10b. County 10d. Inside City Limits Funeral Director 10c. City, Town or Location Laurel M D Howard 1 X Yes 2 No 10f. Zip Code **20723** 10e. Street and Number 10g. Citizen of What Country? 9519 Jaclyn Court United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 😿 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2X No Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pitney Bowes Project Mgr. for Jutice Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ernest. Lee Parker, Sr. **Betty** Jean Brownley 19a. Informant's Name/Relationship (Type, Print) 19b. 746 6 ddress (Street and Number or Rural Route Number, City or Town, State, Zip Code) 760 Wolford Way, Lorton, Virginia Joanne Parker 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 1/11/2011 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem Park 22. Name and Address of Facility McGuire Funeral Service, Inc. Signature of Funeral Service License no 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death SORMA Physician/ disease or condition resulting in death) Medical Examine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury cate has been signed by the attending physician and page 2 should be detached for use as the burial ansit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate has performed Yes 2 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital 1 Yes 2 No ျ patient 2 ER/Outpatient 3 DOA Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural 5 Pending iniury ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined n 24 hours a Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner. In the best of my hourseless that the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29b. Signature and title of certifie 2 29c. License number 29d. Date signed (Month, Day, Year) MUD58182 12/26/10

Registrar
DHMH 17 Rev 7/2009

State

m.D. 7500 Hanover Parkway, Site 101A, Greenbelt, m.D.

and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

(ECII D. (CORGL 81. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dect. 30, 2010 2040 Dolores Peralta Maura De Los Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Holy Cross Montgomery Hospital Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Min 9 //opt 8 /an 194 9 **Director** none 61 Guartemala Usual Residence of Decedent 28a-f show 10a, State 10b. County within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince George' MD Lanham 1 Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8808 Cortland Lane 20706 Guatemala 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 3 ☐ Widowed 4 ☐ Divorced Guatemalan "natural" White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. sant: If item 27 is marked other than 'lury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 6 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Juana Manuela Peralta Filiberto Linares 19a. Informant's Name/Relationship (Type, Print) Daughter Vidalia Betzabe McDonald/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8808 Cortland Lane Lanham, Maryland 20706 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once, 20c. Location - City or Town, State 1/21%2011 cemetery, crematory or other place) Cayuga, Morales, Isabal, Guatemala 1X Burial 2 Cremation X Removal from State Municipal Cemetery 4 Donation /5 Other (Specify) 21. Signature 😼 Service Lice PATTIPOUS TWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the descape, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Congestive heart failure Sequentially list conditions if any, hading to immediate Examiner Due to (or as a nonsequence of cause. Enter Underlying - and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Non-Stemi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Month Pregnant at time of death Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by S/P Bradycardiac arrest, acute renal failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Diabetes millitus performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 **X**No Other: 2 1 Tes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🖾 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contributing Nurse Practicion 1. The basis of my knowledge, death occurred to the long, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certife 29c. License number 29d. Date signed (Month, Day, Year) D68096 Dec.31,2010

Registrar
DHMH 17 Rev 7/2009

State

1500 Forest Glen Road Silver Spring, Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Satyam Shah MD

JAN U5

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G911 1/31/2011 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lee Mary Allen Page Medical 2010 8:00A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Forestville Nursing Facility Forestville PG5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 1 F Country) t. Lawn Months Days Hours (Month, Day, Year) Min. Director 231-26-6363 1917 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 29a or 29a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 😾 Yes 2 □ No Virginia Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1420 W. Abington Drive 22314 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed 3x Widowed 4 ☐ Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry JARDIO PUlMUNARY T Baltimore, Maryland 21215 (Specify only highest grade completed) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12th \end{array}$ College (1-4 or 5+) Domestic Private Family Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Allen Ammie Ingram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Allen (Nephew) 4818 Sheriff Road, NE, Wash. DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Ezell Cemetery 01 - 08 - 11Chester SC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Washingting DC 2001 Dunn & Son Funeral Home 5635 Eads St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmunary Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, Examiner Lue to (or se a consequence of) if any leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Hyperlipidemia attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has autops performed Yes 2 No 2 No Yes 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 V Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) MO 2010 951520 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Bahram Pishdad

31. Date filed (Month, Day, Year)

JAN 31

Ste. 310 Washington, D.C. 20032

1328 Southern Ave.

32. Registrar's Signature

1 - State Amend 5-22 per hosp. g912 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Ange1 Jesus Ruano JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Civisto Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗷 M 2 🗌 F Months Min 6/4/10 Director Usual Residence of Decedent show 10a State Charles at Waldorf Location Director ar than "natural", or items 23a or 28a-f sl the Medical Examiner must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20603 4580 Grouse Place Honouras 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 X Yes 2 ☐ No Specify. If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other t any injury or other traumatic event, the once, 0 Infant Infant 0 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Fredy Ruano Xiomara Patricia Castro-Ochoa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Xipmara P. Castro-Ochoa 20603 4580 Grouse Pl. Waldorf, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify hosp. Cremation 6/25/10 Signature of Funeral Service Licensee 22. Name and Address of Facility Daphne Gray (per DVR) Civista Medical Center 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Extreme disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Dusite (or as a consequence of): the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No ed by the a detached f 9 Unknown P.O. I sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 24a. Was an autopsy performed? Yes 2 No e Hospital or Attending Physician: The I 24 hours after death. • Funeral Director: After this certificate h 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> 20c. Location - City or Town, State **Baltimore** Approximate Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
>
> 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) met **ORIGINAL**

3. Time of Death

9. Birthplace (State or Foreign

Honouras

10d. Inside City Limits

1 X Yes 2 No

Country)

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year) JAN 0 6 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

gnature A. Jank

00069829

10-10058 Lola Royce

Amend Item 21 per FH G912 2/24/11 dk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death	Reg. No		01
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	Year	3. Time of Death
edical Examine	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	December 28,	c. County of Deat	
	3909 New Haven Court Apartment C-10 Bowie 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.		Prince Georg	
Funeral Director	579-40-2408 1 M 2 X F 79 Yrs. Months Days Hours Min.	June 28,	1	
v any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		-	10d. Inside City Limits
Maryland 28a-f show d at once.	MD Prince Georges Bowie	140- 0	tizen of What Cou	1 X Yes 2 No
the Maryland to 28a-f shriffed at once	3909 New Haven Ct. Apt C-10 10f. Zip Code 20716	109. C	USA	and y?
2 -				rican Indian, Black,
er death with , or items 23 r must be no	Never Married 2 Married 1 Yes 2 No 2 N	, 110411, 0101,		White
urs afte	or Dates:		Kind of Business	/Industry
ල _{සි ස} ම් 9	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Administrative Assista		Navy U.S	5.
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maide	n Surname)	
27215-00. 3 27215-00. 3 27215-00. 3 27215-00. 3 27215-00. 3 27215-00. 4 27215-00.		L. Fuller	City or Town Stat	e Zin Code)
MD 21 d 2 should d 2 should tth and Me a 27 is ma iumatic ex	Ledra L. Bailey/ Daughter 14306 Mount Oak Road			6, Zip 0006/
Te, N 1 and 1 1 Health fitem cr trau	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c	. Location - City o	
Baltimore, semit. Pages I au Separtment of Hee Important: If ite	4 Donation 5 Other Specify: Atlantic Crematory 1/3		alen Buri	
Baltimore, MD 21215 permit. Pages I and 2 should be file. Important: If item 27 is marked of injury or other traumatic event, the	21. Signature of Funeral Service Licensee William A Smith per DVR M00544 22. Name and Address of Facility Ro 16000 Annapolis R	bert E. Ev oad Bowie		
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	r respiratory arrest, sl	nock, or heart	Approximate Interva Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death
	Sequentially list conditions, b			
- iner	if any, leading to immediate Due to (or as a consequence of): C. C.			
ed nsit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
execution and and and tra				
760, ficate be g physica the bun	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy		3d. Date of delive Month	ry Day Year
	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregna 4 Pregnant at time of death 5 Other (Specify)		World	ou, iou
by the attent of the death of the attent of	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	use contribute to	the cause of death?
		1 Yes 2	✔No 3 Pro	obably 4 Unknown
07 5 5 2 0		24a. Was an autopsy		utopsy findings available completion of cause of
Record The law req Ticate has bee page 2 shou		performed? 1 Yes 2		′es 2 No
	25. Was case referred to medical 26. Place of Death (Check of	only one) g Home 5 Resid		
그 로 급 그	1 Ves 2 No 1 Impattent 2 Ervourpatient 3 DOA 4 Invisin	28d. Describe how in		er, Scene
ion C tending eath. for: Af the fun	1 V Natural 5 Pending 2 Accident Investigation (Month, Day, Year) 1 Yes 2 No			
0 4 5 3 6 C	3 Suicide 6 Could not be determined	28f. Location (Street or Town, State)	and Number or R	ural Route Number, City
a - = >	1/98. Celuller . A see to the first transfer of the first and place and pl	due to the cause(s) a	and manner as sta	ited.
To the Hospi within 24 hou To the Funct completely fi	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.			
E 3 E 8	1 4 6 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Date signed (M	
FAV	O.C.M.E.	De	cember 31, 2	.010
av	Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD	re, MD 21223		
Stat	31. Date filed (Month Day, Year) 2011 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December 22, Physician/ 2010 1:45 AM John Elmer Stokes III Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick College View Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 4/22/1924 Months 1 🗓 M 2 🗆 F Maryland 86 Yrs. 216-16-4026 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d Inside City Limits 10b. County 10c. City, Town or Location Director Annapolis Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21403 1138 Bay Ridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2X Married Yes 2 No Yes, Give þ Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: White WWII Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry during most of working (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) USNA Plumber Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Margaret Freeman Frank Austin Stokes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10741 Green Valley Rd, Union Bridge, MD 21791 19a. Informant's Name/Relationship (Type, Print) Fern Augusti - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Hillcrest Mem Gardens 12/29/2010 Annapolis, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home Mycling Wohert 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementio Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last s been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hask autopsy page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 2 No ဂ္ 1 🗌 Yes Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 I ER/Outpatient 3 DOA After this 27. M. nne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MB 21702

State Registrar DHMH 17 Rev 7/2009 Shal

JAN 06

31. Date filed (Month, Day, Year)

Ohnson Dr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 0107 M ANGLER Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** JM977 04 1944 Washington, DC 66 213-42-8006 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a, State filed within 72 hours after death with the Maryland Director 1X Yes 2 □ No Prince Georges Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20716 1304 Parkington Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. ural", or iten I Examiner n Armed Forces? Black, White, etc. ò 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Computer Software Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H Important: If item 27 is marked off any injury or other traumatic aurone. 17. Father's Name (First, Middle, Last) Jean R. Dorton Ayers Moppin Spangler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1304 Parkington Lane Bowie, MD 20716 19a. Informant's Name/Relationship (Type, Print) Carol Spangler/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Veterans Cemetery 1/13/2011 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Se 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between set and Death TUITEONCHROMIC CONGESTIVE HEART FAILURE Immediate Cause (Final Ph_ician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami The law requires that the death certificate be executed and tran resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ENAL FAILURE ACUTE & CHRUMC 1 Yes 2 No 3 Probably 4 tonknown Completed ADRICO MITRAL 24b. Were autopsy findings available DISEASE 24a. Was an prior to completion of cause of death? has autopsy performed? KESPIRATTO RY 1 🗌 Yes 2 🗌 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural 5 - Pending Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certifier onuary 02 2011

State Registrar 31. Date filed (Month

M 445

32. Registrar's Signature

FENSE HWY

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State	State of	of Marylan		ertment o				0.0		10170
			Registrar 1. Decedent's Name (First, Middle, Last)			- 061	incate o	Dean		2. Date of Dea	Reg. No.		3. Time of Death
	Physicia		Jean Dryden That	cher						Decemb	er 28,	2010	1:33 AM M
	Medic Examin		4a. Facility Name (if not institution, give str	eet and nun	nber)		4b. City, Town	, or Location	on of Death		4c. County		
			Hospice of St. Ma	ary's			Ca1	laway	7		St	. Mar	v's
	Funeral Director		5. Social Security Number $\begin{array}{c} 6. \text{ Sex} \\ 215-16-3569 \end{array}$	M 2 💢 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Ye Months Day		der 24 Hrs. s Min.	8. Date of Birt (Month, Da Aug 16	h , Year) , 1923	9. Birthp Coun Mar	place (State or Foreign try) yland
	d it	_	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Loc	ration			101		T	0d. Inside City Limits
	arylan a-f sh fied a	5	MD St. Mary	716	100.01			1r					1 ☐ Yes 2 ☑ No
	or 28g	[발	10e. Street and Number	у 5		rextii	gton Pa				10g. Citizen of	What Cour	
	with the 23a cast be	ia	19315 King James	Park W	Vay			2065	3		US		,
	ems ems	ğ.		2. Was Dece	edent Ever in U.S	S. 13. V	Vas Decedent o	f Hispanic	Origin? (Spe	cify Yes or No-	14. Rac	e - Americ	
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛛 Widowed 4 ☐ Divorced	Armed For 1 Yes If Yes, Give Year or Do	2 X No √e		Yes, specify C			Rican, etc.)	Specify	ck, White,	_{otc.} √hite
ŏ	natur lical	lete	15. Decedent's Educ	cation			ent's Usual Oc				16b. Kind of B	usiness In	dustry
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2	d with lygien her ti	Be C	12		0	l	nursing				health		unk
and	ntal Hed on ted of ed of ed of ever	To B	17. Father's Name (First, Middle, Last) Frank Dryden					18. Mo	other's Name	e (First, Middle,	Maiden Surnam	e)	
Maryland 21215-0036	mark		19a. Informant's Name/Relationship (Type	Print)		10b Mailin	a Address (Stre	et and Nur	wher or Rura	I Route Numbe	r, City or Town, S	State Zin (Code)
S ≥	12 shullth ar 127 is rtrau		Eric Schuerholz/g		on	19315	King J	lames	Park	Way Lex	ington,	Park	, MD 20653
ē	1 and of Hea item othe		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of			Date	20c. Location		
E	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 🔀 Donation 5 ☐ Other (Specify)	emoval from	State C	cernetery, cren	natory or other p	olace)					
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Euneral Prvice Licen	nde, 1	irector	s St	are and Ada ltimore	-			Baltim	ore S	treet
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L,	Ph. sician/		shock, or heart failure. List only one Immediate Cause (Final	cause on ea	activine	100	Ca	110	01				Interval Between Onset and Death
	Medical		disease of adition resulting in death)	Due to	(or as a conseq	uence of):	- (11	NU				_	
	Examiner		Sequentially list conditions, b.										
	p #	Examiner	n any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of).									
	and trans	xan	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to	(or as a conseq	uence of):						-+	
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760	cate t	edic	d.										
687	certifi nding use a	Ž/	IF FEMALE: 23b. Was decedent pregnant 23		tcome of pregna] F-t:-				23d. Da	ate of deliv	ery
Вох	law requires that the death certificate be executed has been signed by the attending physician and e 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Preg	Birth 2 Feta gnant at time of nown	death 5	Ectopic pregr Other (specify				M	onth	Day Year
P.O.	at the	, Ph	Part II. Other significant conditions conf	ributing to o	death but not res	sulting in the u	nderlying cause	given in P	art I.	23e. Did t	obacco use con	tribute to t	he cause of death?
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<u>=</u>	sician: The lar certificate ha lirector, page 2	Be C	25. Was case referred to medical				26	. Place of [Death (Check		2 LA (NO)	1	
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<u>o</u>	ing Pl		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date (Mor	of injury oth, Day, Year)	28b. Time of injury	v	njury at vork?	- 1	28d. Describe I	now injury occur	red	rung
į	ttend death stor: A	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	200 Place	e of Injury - At he	omo form str		Yes 2		20f Location (Stroot and Numb	or or Pum	I Route Number,
Division of Vital Records,	l or A	Se	4 Homicide determined	build	ing, etc. (Specify	y)	set, factory, om	oe .		City or Tov		er or riora	rioate Namber,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and for the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic	Medical	29a. Certifier 1 Certifying Physic (Check Medical Examine	ian: To the l	best of my know	n and/or inves	tigation in my o	ninion deat	h occurred at	the time date :	and place and du	ie to the ca	ed. ause(s) and manner stated.
	the H thin 24 the F	Me	only one) 3 \square Certifying Nurse			y knowledge,	death occurred a	t the time,	date and plac	e, and due to th	e cause(s) and m	anner as st	tated.
	5 ½ € S		29b. Signature and title of certifier		11	$\overline{}$	29c. LIO	AA 5	570	- /	29d. Date signe	Givionin,	Day, rear)
			20 Name and address (mpleted as	se of death (Item	n 22al (Time 5	Print)	000	773	'	1		2010
			30. Name and address of Person Who cor	inpieted cau	+ " T/) 4	0900 1	Meca	·had	chn s	e cause(s) and m 29d. Date signs 2016	55 1	eonardhun MD
	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Signa	ature		} ~					1/
	Registra	ar	FEB 0 3 20°	11 /	news	B. A.	arks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 30, 2010 Physician/ Terrence Roy Thomas 10:26 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 🕅 M 2 🗆 F Months Davs Hours Min. (Month, Day, Year) Feb. 19, 1954 Country) Jamaica Director 057-76-4138 56 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland Director 1 Yes 2 X No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 20904 TISA 11653 Lockwood Drive death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Examiner Black White etc. 1 Never Married 2 Married 0 þ 1 Yes 2 No If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: Specify. "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Hygiene. permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the I Security Protective Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lydia Hancherd Harold Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11653 Lockwood Drive, Silver Spring, MD 20904 Sylvia V. Thomas/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Jan. Gate of Heaven Cemetery 2011 4 Donation 5 Other (Specify) Silver Spring, MD . Signa ure Friels J. Collis Tuneral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Harris and Address of Inglith Funeral Home 23a. Part 1. Enter the disease, or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Acute Myocardial Infarction Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) as the burial-transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Month Year Pregnant at time of death ☐ Pregnam ☐ Unknown detached Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ Obesity, Hyperlipidemia, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 performed? Yes 2 No certificate Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? Hospita Other: 2 No 1 X Yes 은 1 Inpatient 2 ER/Outpatient 3 N DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred hours after death. (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined To the Hospital o within 24 hours af To the Funeral Di Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, or my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) H59837 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Khanh Q. Nguyen, MD 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 5 Registrar

	•		1 - State of Maryland / Dep Registrar Ce.	ertment of E		ınd Mental Hy	rgiene Reg. No. 201	0-43181	
	Dhusisis		1. Decedent's Name (First, Middle, Last)			2. Date of De	eath	3. Time of Death	
AL.	Physicia Medic	n/ al	Arnold A. Cohn			Decembe	er 29, 201	0 5:25 P M	
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A PARTICION AND AND AND AND AND AND AND AND AND AN			2301 Glenallan Ave. #316 5. Social Security Number 6. Sex 17. Age (In vrs. last birthdav)	S11v	er Spr I If Under 2			gomery	
	Funeral Director		5. Social Security Number 6. Sex 1 ★ N 2 □ F 7. Age (In yrs. (ast birthday) 7 Yrs.	Months Days	Hours 2		ay, Year 1919	Birthplace (State or Foreign Country) New York	
			Usual Residence of Decedent			рее. 1	1, 1919 New York		
	rland f sho	tor	10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits		
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	th the	alD	10e. Street and Number	10f. Zip Code			10g. Citizen of Wha	t Country?	
	ms 2 must	Funeral Director	2301 Glenallen Ave. #316	20906		0/0 77 77	USA		
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Maryland 21215-0036	ntal Fred o	To E	Morris Cohn			's Name <i>(First, Middle,</i> [da Ludwig	Maiden Surname)		
2	ould by mark			ing Address (Street		or Rural Route Number	City and Town City	Zin Codo) 20905	
Š	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		, , , , , , , , , , , , , , , , , , ,			ourt, Silve			
Itimore,	1 and of Heg		20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place	ما	Date	20c. Location - City	y or Town, State	
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0	The law requires ate has been sign page 2 should be	Completed				24a. Was		autopsy findings available	
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	rtifica ctor, p		25. Was case referred to medical examiner?	26. Pla	ice of Death	(Check only one)	2 110	165 2 110	
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o '	ing P		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury	f 28c. Injury work?	at ?	28d. Describe h	now injury occurred		
0	tendi death tor: A the fi	įį į	2 Accident Investigation	M 1 🗆 🕆	Yes 2 N	lo			
Division of Vital Records,	or Al after a Direc in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, streen bullding, etc. (Specify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,	
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	n 24 h	Med	(Check 2 ☐ Medical Examiner: On the basis of examination and/or invest only one) 3 ☐ Certifying Nurse Practigner: To the best of my knowledge, or	tigation, in my opinior	n, death occi	urred at the time, date a	and place, and due to t	he cause(s) and manner stated.	
	to the Nospital or Attending Physician: The law within 24 hours after death. To the Funeral Directors After this certificate has i completed filled in by the funeral director, page 2 second the property of the funeral director, page 2 second the property of the funeral director.		29b. Signature and title of ceptilier	29c. License			29d. Date signed (Mo		
	15		· Whence	D263	82		01	/13/2011	
			30. Name and address of person who completed cause of death (Item 23a) (Type, P	,				007/0	
			Marc Shepard, MD 4700 Berwyn House 31. Date filed (Month, Day, Year) M. Registrar's Signature	Road #10	4 Coll	lege Park,	Maryland	20 / 40	
	State Registra	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ALS!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:09 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 4940 Fastern ALE Baylato UUSPHOS Ra Homire Ballsmure. If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Hours Min. (Month, Day, Year) 5-4-194] 69 **Director** 214-54-6137 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 2006 N. Washington Street 21213 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) School llth grade æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nannie Foster Law Mobley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Moore, Sr-Son N. Washington Street Balto, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Carmel Cem Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 1-3-2011 4 ☐ Donation 5 ☐ Other (Specify) Balto, MD Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a nsequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 2 1 Inpatient 2 ILER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 5 \square Pending X Natural Investigation 2 Accident
3 Suicide
4 Homicide Director: did not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined า 24 hours ส e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 20676 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bayrieur 4940 EOSTETA Are BAHME 31. Date filed (Month, Day 32. Registrar

Joseph Lester lan		arino S 1- For State Registrar	state of Marylar		artment of rtificate of		and Mei	ntal Hy		Reg. No. 201	0-43183
Physiciar Medical Examin	n/	1. Decedent's Name (First, Mid- Joseph Lest		ino					. Date of Dea		3. Time of Death 1352 hrs
		4a. Facility Name (if not instituti 1744 Wentworth Ave		ber)		b. City, Town, Parkville	or Location	of Death		4c. County of Baltimore	
Funeral Director		5. Social Security Number 212-94-2413	6. Sex 7	. Age (In yrs. I 45		If Under 1 Y	ear If Und				Birthplace (State or Foreign Country) WV
faryland 28a-f show any Latonce.			imore	-	Town or Locati	е					10d. Inside City Limits 1 Yes 2 X No
h the Mary	[발	10e. Street and Number 1744 Wentwo	rth Ave			10f. Zip Code 212] 1	10g. Citizen of Wha USA	
safte	by Fune		vorced If Yes, Give Year	2 No	1	S Decedent of les, specify Cub	oan, Mexicar	n, Puerto Ri	ican, etc.)	White, Specify:	White
0036 within 72 hour giene. her than "natu Medical Exan	Completed	15. Decedent's Education (Specific Relementary/Secondary (0-12) 1 2	College (1-4			rs Usual Occup ost of working I mber	ife. DO NOT	ruse retired	d)		truction
21215-0036 Juld be filed within 7 Mental Hygiene event, the Medica	P P	17. Father's Name (First, Middle Lester R. Ia	mmarino		1.0.		Ма	ry A	nn Er		
MD 2 nd 2 shoul alth and M im 27 is in	_[19a. Informant's Name/Relation: Mary Ann Iam 20a. Method of Disposition		other	1744	Went	vorth	Ave	Park	mber, City or Town, Ville M	D 21234
Baltimore, permit. Pages I a Department of He Important: If ite Important: If ite Imjury or other tr		1 Burial 2 Cremation 4 Donation 5 Other S	pecify:		Place of Disposi prematory or oth Lantic	Crem		01/0		Glen B	urnie MD
		21. Signature of Funeral Service	All		22. N	omasA	ss of Facilit LlenP	Simp A 70	licit 90 Ri	y Crem dge Rd	& Fun Serv Hanover MD
Physician Wadical Examiner		23a. Part İ. Enter the disease, or failure. List only one cause immediate Cause (Final disease or condition resulting in death)	on each line. e a. Cardiac Due to (or as a co	Arrhy onsequence of	thmia		g, such as d	cardiac or re	espiratory am	est, shock, or heart	Approximate Interval Between Onset and Death
Traming the many of the many o	Yalliller	Sequentially list conditions, f any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last	b. Dilated Due to (or as a co	nsequence of):	ny					
oe execuician and irial - tra		X UNPENDED	d. AMENDED	23a,b,	pt.II,2	7 per n	ne g91	1 1-2	0-11 v	rt	
Sox 6876 leath certificate e attending phy for use as the l		F FEMALE: Bb. Was decedent pregnant in the past 12 months? I Yes 2 No 9 Unit	4 Pregnant	at time of dea	2 Feta	il death 3 er (Specify)	Ectopio	c pregnancy	<i>'</i>	23d. Date of de Month	livery Day Year
, P.O. E res that the d signed by the be detached by by Physical B		Part II. Other significant conditions Methadone Use	g	eath but not re	sulting in the un	derlying cause	given in Pa	art I.			te to the cause of death? Probably 4 Unknown
of Vital Records, P.O. og Physician: The law requires that th ther this certificate has been signed by meral director, page 2 should be detach n: To Be Completed by P									24a, Was a autop: perfor 1 Yes 2	sy prio med? dea	re autopsy findings available r to completion of cause of th? Yes 2 No
f Vital F Physician: rr this certifical director, I	L	 Was case referred to medica examiner? 1 ✓ Yes 2 No 	I Hospital: 577	atient 2 1	ER/Outpatient		Other ₄			Residence 6 🗸	Other: Scene
sion of Attending Phydeath. ttor: After tilly the funeral	2	7. Manner of Death 1 X Natural 5 Pend 2 Accident Inves	28a. Date of I (Month, Date) ding stigation	njury y,Year)	28b. Time of Inj	· I _	ury at Work		d. Describe h	now injury occurred	
Division of To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the funeral Adedical Certification:			d not be 28e. Place of (Specify)	Injury - At hor	me, farm, street,	factory, office	building, et	c. 28	f. Location (S or Town, St		or Rural Route Number, City
To the Ho within 24 To the Fu completely	0	check only 2 Medical Example 1	nysician: To the best of miner: On the basis of ex and manner state	xamination an							
	2	9b. Signature and title of certifie	Levelar			29c. Licen	se number .M.E.			29d. Date signed December 30	(Month, Day, Year)
ϕ	3	D. Name and address of person Carol Allan, MD Ass	who completed cause of sistant Medical Exa		- /	nore Street	, Baltimo	ore, MD 2	1223		
State Registra	4	1. Date filed (Month, Day, Year)	32. Regist	rar's Signature	e						

hillip Barnett Kir		1- For State Registrar		ate of Maryla		artment of ertificate of		l Mental H	ygiene R	eg. No. 201	0-43184
Physicia Medical Examin		1. Decedent's Name Phillip			5				Date of Dea Month Decembe	th Day Year r 26, 2010	3. Time of Death 2154 hrs
\bigcirc		4a. Facility Name (if Frederick Me			mber)	-	4b. City, Town, or L Frederick	ocation of Death		4c. County of Frederick	Death
Funeral Director		5. Social Security Nu 213-76-61	26	6. Sex	7. Age (In yrs. 40	last birthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_	Tr.	9. Birthplace (State or Foreign Country) MD
, any	ł		0b. County			y, Town or Locat					10d. Inside City Limits
faryland 28a-f show	혉	MD 10e. Street and Num		lerick	F	rederick	10f. Zip Code			On Citizen of Miles	1 X Yes 2 No
th the Maryland 23a or 28a-f sbo botified at once.	Director			., Apt. A			2170	1		0g. Citizen of What USA	Country?
er death wi , or items r must be	Funeral	11. Marital Status 1 X Never Married 3 Widowed			2 X No	If Y	is Decedent of Hispes, specify Cuban,	Mexican, Puerto		White, e	American Indian, Black, etc. White
iours afi natural'	g p	15. Decedent's Edu	ucation (Spe	or Dates: cify only highest grad		16a. Deceden	it's Usual Occupation	on (Give kind of		16b. Kind of Busin	ness/Industry
5-0036 ted within 72 h Hygiene. other than "r	Completed	Elementary/Secon		College (1	-4 or 5+)		ıck Drive	r		Produc	e Co.
	Be C		Father's Name (First, Middle, Last) John King Sr. 18. Mother's Name (First, Middle, Maiden Surname) Karen Gold Informant's Name/Relationship (Type Print) 19h Mailing Address (Street and Number or Pural Pouts Number City or Town State Zin								
MD 21 d 2 should th and Me a 27 is ma	의		Informant's Name/Relationship (Type, Print) John King Jr. – Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip (7025 Holter Rd., Middletown, MD, 21769)								
ore, sell and of Heal		1 X Burial 2	Method of Disposition Method of Disposition (Name of cemetery crematory or other place) Donation 5 Other Specify: Donation 5 Other Specify: Date 20c. Location - City or Town crematory or other place) Lutheran Cemetery 12/30/2010 Middletown,								
Baltimo permit. Page Department of Important: injury or oth		21. Signature of Fundantal T			DVR					Thompson, MD 2176	Funeral Home
Physician /Medical caminer	1	23a. Part I. Enter the failure. List only Immediate Cause (F	one cause inal disease	on each line.		h. Do not enter th					A CONTRACTOR OF THE PARTY OF TH
A. A.		or condition resulting		Due to (or as a	consequence	of):					
	Examiner	if any, leading to imm cause. Enter Under (Disease or injury that	lying Causa	Due to (or as a							
cuted md transit		events resulting in de	eath) Last	Due to (or as a		·.					
50, te be executed ysician and burial - transit	ledical	UNPENDED					2,02/09/2	011dhb	37128 ₁ 1	er me g9	13
x 687(h certifica tending ph	ΣΙ.	IF FEMALE: 23b. Was decedent p past 12 months?		1 Live b	ant at time of d	2 Fe	tal death 3 her (Specify)	Ectopic pregna	ancy	23d. Date of de Month	Day Year
that the deatled by the att detached for		Part ii. Other signifi		9 011810		resulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?
cords, P.O. law requires that the has been signed by 2 should be detact	ted by						. =		1 Yes		Probably 4 Unknown
	Completed	25. Was case referre	46				00.01		autop perfo 1 ✔ Yes	rmed? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Vital bysician this cert	2 2	examiner?	No No	Hospital: 1 1		ER/Outpatient		of Death (Check Other Nursin		Residence 6	Other:
ttendii death.	Certification:	27 Manner of Double									
Divisual or / urs after real Dire	E L	28e. Place of Injury - At home, farm, street, factory, office building, etc. 4 Homicide Could not be determined Specify) Single Family Home 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 790 Wembly Drive, Frederick, Md								or Rural Route Number, City Md	
2-12	Medical C			nysiclan: To the bes miner:On the basis of and manner s	of examination						
F ×F o	ž	29b. Signature and ti	tle of certifie				29c. License O.C.N			29d. Date signed December 2	(Month, Day, Year)
	-	30. Name and address				,				December 2	
Sta	Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature										
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10-09740

anet Lange		Registrar	artment of rtificate of		d Mental H	Re		-43185			
Physici Medical Exami		Decedent's Name (First, Middle, Last) Janet Lang				Date of Dead Month December		3. Time of Death 1706 hrs			
		4a. Facility Name (if not institution, give street and number) 5203 4th Street	4	b. City, Town, or L Brooklyn	ocation of Death		4c. County of De Anne Arund				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Is		If Under 1 Year Months Days				eign			
		215-74-3905 1 M 2XF 50 Usual Residence of Decedent	Yrs.			11-28	-1950	Country) MD.			
ow any			Town or Location					10d. Inside City Limits 1 X Yes 2 No			
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h the M 3a or 2	<u>D</u>	5203 4th Street		21225	5		USA				
r death with the Maryland or items 23s or 28s-f sho must be notified at once.	Funeral Director	11. Marital Status 1 X Never Married 2 Married Armed Forces? Armed Forces?		s Decedent of Hisp es, specify Cuban,			- 14. Race - Am White, etc	erican Indian, Black,			
after d	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 No			Specify:	White			
72 hours a "natu		Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		s Usual Occupations of working life.			16b. Kind of Busines	s/Industry			
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be	Author Green				ne Rose	Maiden Surname) Lang				
AD 21 2 should 1 and Me 27 is ma matic e	7	19a. Informant's Name/Relationship (Type, Print)	mberly Regiec/ Friend 1511 Cypress St. Baltimore, Md. 2122								
s 1 and f. Health	8	20a. Method of Disposition 20b. F	Neithcd of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - Comparison of Comparison								
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		ney Crema			Woodbine				
Depa Impo		Charisse N. Woods per dvr					more, Md.	uneral Svc. 21223			
Physician Medical	8 14	23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	Do not enter the	e mode of dying, s	uch as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death			
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Cirrhosis of liver Due to (or as a consequence of	f):					Deau			
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
	Examiner	cause. Enter Underlying Cause (Dissess or Injury that initiated events resulting in death) Last	<i>i</i>):		(# 15°						
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60, ate be eathysician	Medical	IF FEMALE: 23c. If yes, outcome of pregr					23d. Date of delive	ery			
Box 6876(e death certificate the attending physel for use as the b	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of dea	2 Feta	al death 3 er (Specify)	Ectopic pregna	ncy	Month	Day Year			
D.O. BOX that the death ned by the att	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not re			an in David	22a Did tab		to the cause of death?			
, P.O.	<u>a</u>	Part II. Other significant continuous continuous continuous	sulting in the un	derlying cause giv	en in Part I.			obably 4 Unknown			
cords, F law requires has been sign	Completed					24a. Was a autops	sy prior to	autopsy findings available completion of cause of			
tal Rec		25. Was case referred to medical		26 Pleas	f Dareth (Charles	perform 1 Yes 2	med? death? 2 No 1 ✓				
Vital Rec hysician: The this certificate	o Be	examiner?	ER/Outpatient		f Death (Check of ther Mursin		Residence 6 🗸 Oth	er: Scene			
Ision of Vital Records, P.O. Box 6876. Attending Physician: The law requires that the death certificate r death. The thin cetor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the b	Ë	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	ow injury occurred								
24a. Was an autopsy performed? 1								Rural Route Number, City			
Ospital ospital hours a uneral I	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 29f. Location (Street and Number of or Town, State) 29g. Certifier (Check only 1 Check only 1 Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as:										
Divi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination an and manner stated.									
L > F 3	Ž	29b. Signature and title of certifier		29c. License r			29d. Date signed (MD) December 18, 2				
		30. Name and address of person who completed cause of death (Item:	23a)	J.C.IVI.	· - ·						
Margarita Korell MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											
Sta Regist		1. Date filed (Month, Day, Year) 32. Figistrar's Signature,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Items 25,27,28a,b,c,d,e,f,per me,g912,02/04/2011dhb Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Physician/ 20TO 4:15 PM Jeffrey D. Moore Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Joseph Richey Hospice 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours March 22, 1961 Maryland 49 Director 217-80-1704 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1537 Montpelier Street 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, et ð 1 → Never Married 2 Married Maryland 21215-0036 hours after black 1 ☐ Yes 2 🖺 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry $\overline{\, unk}$ permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) cement finisher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Moore Woodrow Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Moore - mother 1537 Montpelier Street; Baltimore, MD 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Funeral Strice Licens Signatur 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or con n resulting in death) Physician/ Medical Due to (or as a consuence of Examiner Sequentially list conditions, if any leading term in clate cause. Enter Underlying Cause (Disease or linjury that is the last of the cause (Disease or linjury) Examine sician and burial-transit that initiated events resulting in death) Last inding physician use as the burial Physician/Medical use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atte should be detached for in the past 12 months? Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 图 Other (Specify) けっちょうしと 1 X Yes 2 23 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred Subject passenger in a motor vehicle that collided with a motor vehicle 28a. Date of injury 28b. Time of Certificate: 28c. Injury at Hospital or Attending 5 Pending 1 Natural 2 Accident 01/17/2000 6:12 p.M 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Perring Parkway at Hillsway Avenue, Parkville, MD** 4 Homicide determined Roadway Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date şigned (Month, Day, Year) 0002290 30. Name and address of person who completed cause of feath (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

てるよういのと

Registrar's Signature

Registrar

Box 68760

Records,

Division of Vital

State

Cheverly

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravinder K.

Landover

8

31. Date filed (Month, Day, Year)

Road

12/09/2010

M.D.

20799

Rustagi,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, g912,02/04/2011 dnb

Certificate of Death

Reg, No. T = For State Registrar edent's Name (First, Middle, Last) 2. Date of Death Kins Physician/ SECTEM BEZ IN Year 3.55 A M Medical (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HNNE BAGIMORE VOASHINGTON MEDICAL CR GIEN BUZNIE HAUNIZE Age (In yrs. 5. Social Security Number last birthday If Under 1 If Under **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) Months Hours Min 12-284-1921 Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 10d. Inside City Limits MD Devern 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1907 12. Was Decedent Ever in U.S. Armed Forces?
1 ★ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Pao Specify. ₩idowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation Gerorde's (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. nday (0-12) College (1-4 or 5+) OSEPH Be ပ္ とれている。 9a. Informant's Name/Relationship (Type, Print) aga\ddress (Street and Number or Rural Mber, City or Town, State, Zip Code) of Health MD 21076 tenover Oonά 20b. Place of Disposition (Name of cramatory or other place 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ò mportant: If 4 ☐ Donation 5 ☐ Other (Specify) any injury Ho. re of Funeral Service Line 21. Sig 1 t 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final PAILUPE Onset and Death Physician/ RESPIRATORY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner TOTILT ANTIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or, ATRALFIBRILLATION attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day been signed by the s 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s autopsy performed? Yes 2 death? certificate 2 🗌 No Yes 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Other ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manual of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending death. 1 🗌 Yes 2 🗌 No Accident within 24 hours after death

To the Funeral Director: A Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar title of certifie MI (4 16 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 18031710 301 475 31. Date filed (Month, Day Year) 32. Registrar's Si State FEB 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State amend 20-22 per hosp. g912 2 definite at of Death Reg. No. 2016 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0849AM Malachi 1 Sajah 2010 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hospital Center George's George's Chever / y
If Under 1 Year If Under 24 Hrs. rince 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Min NIA Yrs Director Maryland Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show if Health and Menial Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28e-1 ehov other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Trince bital HEISKID 10e. Street and Number 10g. Citizen of What Country? 6602 Hd Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Exemples 2008. Never Married 2☐ Married Baltimore, Maryland 21215-0036 Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Infant NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20143 19a. Informant's Name/Relationship (Type, Print) 6602 Bona Briscoe - mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition oc. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ⚠ Other (Specify) hosp. **PGH** 1/10/11 Cheverly, Md. 20785 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ryvette Smith (per DVR) **PGH** 3001 Hospital Dr., Cheverly, MD. 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 62 ming /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien and for use as the burial-transit Hospitel or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 🗆 No 1 Yes director Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 2 No Inpatient 2 ER/Outpatient 3□ DOA this ate of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200

Registrar DHMH 17 Rev 1/2001 GEORGE'S HOSP.

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

32 Programme Signature

03

CHEVERLY MD 2078G

CONTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - Stete amend 20-22 Registrar	per hosp.	g912 <i>2</i>	ertificate 67	Death	F	Reg. No. 2010	-43190
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fr.	Examir		4a. Facility Name (If not institution, give	street and number)	11.1-	4b. City, Town	or Location of Dea	th	4c. County of Dea	ith / square
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	Funeral		5. Social Security Number 6. Se	ex 7. Age	(In yrs. last birthda Yrs.	y) If Under 1 Year Months Days			h 9. Bir	thplace (State or Foreign
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	land ow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
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	deeti	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	B. Was Decedent of I	Hispanic Origin? (Specify Yes or No-	14. Race - Ame	
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alti			21. Signature of Funeral Service Licens		PGH	22. Name and Addre	1/10	-		
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DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

			For State	State of M	larylan		artment of F		nd Me	ental Hyç		010	4/2/01
			Registrar 1. Decedent's Name (First, Middle,	I ast)		Cer	tificate of D	Jeatn		2. Date of Dea		010	
	Physicia			LOFTON					-	Month	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, o				4b. City, Town, or	Location of	Death	OCT 8	4c. County	of Death	12:30 P M
			NATIONAL NAV	AL MEDICAL	CENTE	ER.		BETHESI				NTGO	
	Funeral					ast birthday)	If Under 1 Year Months Days	If Under 24		. Date of Birti (Month, Day	h		place (State or Foreign
	Director		N/A Usual Residence of Decedent	-X *** 2		Yrs.	,		26		2010		MARYLAND
	and show lat	ō	10a. State 10b. County	ш.,	10c. City	y, Town or Loc	cation						10d. Inside City Limits
	Maryl 28a-f otifiec	Director	VIRGINIA SPOTS	YLVANIA	F	FREDER	ICKSBURG						1 ☐ Yes 2 🙀 No
	a or 2	<u>=</u>	10e. Street and Number		-		10f. Zip Code				10g. Citizen of V	Vhat Cou	ntry?
	filed within 72 hours after death with the Maryland death Hygiene. 1 other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at	Funeral	9401 ANDREWS MI				224	·08			US		
	r deat r iten iner i		11. Marital Status	12. Was Decedent I Armed Forces?			Was Decedent of His f Yes, specify Cubar	spanic Origin л, Mexican, F	n? (Specify Puerto Ric	y Yes or No- an, etc.)		e - Americ	can Indian, etc.
38	s after al", o Exam	d b	1 Never Married 2 Marrie 3 Widowed 4 Divorced	ed 1 Yes 2 Y If Yes, Give Year or Dates.	No	1	☐ Yes 2 🙀 No	Specify:				BLA	
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Maryland 21215-0036	<u>a</u> <u>a</u> <u>a</u> ⊆ <u>c</u>		THURMAN RUTH L						_		E BLACK		
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ē,	1 and if Hea item other		20a. Method of Disposition		20b. Pla	lace of Dispos	ANDREWS sition (Name of		LANE Date		20c. Location -		
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Baltımore,	permit, Page Department Important: I any injury or once.		21. Signatury Funeral Service Lic				. Name and Address				wal Med	ical	Center
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T th	vithir comp		29b. Signature and title of certifier	d)	book of fifty is	movicage, ac	29c. License		d place, al		9d. Date signed		
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		7	30. Name and address of person who	o completed cause of de	eath (Item 2	23a) (Type, Pri	int) NATI	ONAL N	JAVAL	MEDIC	CAL CENT	ER	
			CANDICE E. JON		AC US	$\overline{}$	BETH	ESDA M	<u>1</u> D 20	889-56	00		
	State	~	31. Date filed (Month, Pay Year) 20	32. Registra	r's Signatur	re faction	Yes !						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OCT 8 Physician/ ARIN LOFTON 2010 Medical 6:05 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 🙀 M 2 🗆 F Months Days Hours Director Country) Yrs 01 6 MARYLAND Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits VIRGINIA SPOTSYLVANIA FREDERICKSBURG 1 Yes 2 No ems 23a or r must be r 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9401 ANDREWS MILL LANE 22408 US items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. "natural", Completed 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. n N/A N/A Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked oth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည THURMAN RUTH LOFTON JR SHENORA CAPRICE BLACKMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHENORA BLACKMON 9401 ANDREWS MILL LANE FREDERICKSBURG VA 22408 MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it injury or 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) THENA 22. Name and Address of Facilit Bethesda, MD 8901 Rockville Pike 20889 23a. Part 1. Enter the disease, or complications that edused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician EXTREME PREMATURITY (19 wks 231 grams) disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if a y, leading to humediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence o): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ Completed been si should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an certificate has tirector, page 2 s autopsy prior to completion of cause of 1 🗌 Yes 2 🗌 No 1 Yes 2 😾 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 Yes 2 No Other: 1 Malient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, this Certificate: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury 2 🗌 No after death Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 To the I 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar CANDICE

31. Date filed (Month)

arke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MC

32. Fegistrar's Signature

recen

USA

JONES

01011244067 (VA)

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

2010

CENTER

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia Medic				ELIJI		OFT	ON					Month OCT	8 2	010_	Year	6:40 P M
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 A Never Married 3 ☐ Widowed 4	☐ Divorced	If Yes, Gi Year or D	2 🔀 ve	No			2 X No			Rican, etc.)			k, White, BLA	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per dvr g912 2-16-11 vt
State of Maryland? Department of Health and Mental Hygiene Reg. No. 2010 -State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie 7713 Leigh Road 8. Date of Birth (Month, Day, June 4, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthdav) **Funeral** 1 □ M 2 🛣 F Months Days Hours Maryland T919 Yrs. Director 91 217-05-4589 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State be notified at Director 1 Yes 2 No Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a Funeral 21060 USA 7713 Leigh Road traumatic event, the Medical Examiner must "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) healthcare transcriptionist permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked any injury or care. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Blanche Hughes Peter Creager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7713 Leigh Road; Glen Burnie, Maryland 21060 Milton Miles - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Service Wade 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and -transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown P.0. been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. Division of Vital Hospital or Attending Physician: 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 **X**No 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 15 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventionable in more distribution. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 2 person who completed cause of death (Item 23a) (Type, 30. Name a 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Manyland, Department of Health and Menter Hussigner me, fh, g912,02/25/2011 1 - State Registrar Certificate of Death dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WALREN 10 13 PM 106 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UMMC SALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Hours Min. Jumeth, Bay, Y12954 Country) DC unk 56 Yrs Director 577-78-3216 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2X No DC Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20032 USA 1310 Southern Avenue SE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black White, etc. unk 1X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates black 3 Widowed 4 Divorced Completed I Hygiene. other than "natura rent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Day Program Special Ed it. Page 1 and 2 should be filed withintent of Health and Mental Hygiene reart: If item 27 is marked other the njury or other traumatic event, the unk <u>un</u>k Be 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) ٥ Alberta J. Coates 19a. Informant's Name/Relationship (Type, Print) Guardian 19b Mailing Address (Street and Number of Rural Feyter) Weber 1000 Wastrick Con, DC 22-S. Greene-Street Baltimore, MD 21201 20005 -UMMC Wanda Baker-Joseph Department of Health Important: If item 27 any injury or other theore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 07/09/2010 Beltsville,MD in state Chesapeake Crematory 4 ☐ Donation 5 🔯 Other (Specify) 22 Name and Address of Facility, H. Bacon Funeral Home, Inc.

State Anatomy Board 325 W. Baltimore Street
Baltimore, MD 21201344714th St., N.W., Washington 21. Signature of Funer S rvice Licersee Day 101 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Enysician/ toulurE QQN disease or condition Medical resulting in death) Examiner chronic laite Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🗷 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: Certificate; To 1 🄀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? iniury 1 🗷 Natural 5 Pending Accident
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DHMH 17 Rev 7/2009

Registrar

TOME

22

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32 Registrar's Signature

MIKLOSH

31. Date filed (Month, Day, Year)

25

1 - For State Registrar	Amend Items State of 23a,2	f Maryland / Depa 5,27,28a-f pe Ce <i>r</i>	artment of He r me, g912 tificate of De	ealth and ly .02/25/2 eath	lental Hygi 011dhb	iene	-43196
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State 31. Date filed (A	FEB 2 5 2011 32.	e of death (Item 23a) (Type, F 2007 Mole egistrar's Signatury	arked				

10-09598

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State of Maryland / Department of Health and Mental Hydiene

Glenda Lettsome	1- For State Registrar	tate of Maryland /		te of Death	d Mental H	Reg	. No. 2010	
Physician/ Medical Examine	Decedent's Name (First, Midd					Date of Death Month December	Day Year	3. Time of Death
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- P	Prince George's Hos	oital Center		Cheverly			Prince Geor	
Funeral Director	5. Social Security Number 580 – 08 – 9125	6. Sex 7. Age	(In yrs. last birth	day) If Under 1 Yea Months Day Yrs.				Birthplace (State or Foreign Country) Virgin Islands
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b, MD and 2 sho (ealth and tem 27 is traumati	Barry Pryor/ 20a. Method of Disposition	husband	20b. Place of	Jashington Disposition (Name of ce	metery, 2	0.019 Date	20c. Location - City	or Town, State
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Baltimore, permit. Pages I an Department of He Important: If ite	2 Ignature of Funeral Service	Licensee		22. Name and Addres	ss of Facility HO	ges &	Edwards	F.H.
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,	30. Name and address of person			111 Donn Chart	Rollimore MD	21201		
	Victor Weedn MD JE		111	111 Penn Street,		2 1201		
Stat		2011	A. A	parket				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per me,g912,02/25/2011dhb Certificate of Death For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month W 0800 AM ichard Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8 Be<u>linda Avenue</u> Baltimore Baltimore County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth g. Birthplace (State or Foreign 1 M M 2 □ F Months Days June 11/22 2 1918 Director 215 01 1847 Yrs Baltimore Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Baltimore County 1 Yes 2 X No Maryland 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be i with Funeral 21206 USA 8 Belinda Avenue items 2 death 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces Black, White, etc. þ permit. Page 1 and 2 should be filed within 72 hours after of Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 ☐ Never Married 2 🙀 Married 1 Yes 2 No If Yes, Give Year or Dates. 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cloverland Milk Man To Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Genevieve Plowman Leonard Schoenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21206 Elma M Schoenberger (Wife) 8 Belinda Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burlal 2 Cremation 3 Removal from State Parkwood Cemetery December 28 2010 Baltimore.Marvland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Signa ure of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immedicause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 L 9 Unknown Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy certificate 2 🗌 No 1 Yes Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Yes Z Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: It the basis of my knew edge, deligrating the life, and due to the cause(s) and the manner at entired. (Check 29b. Signature and title of certifier License number

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 201

31. Date filed (Month, Day, Year)

amend items 20a-c per fh g916 6-8-11 vt
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items 20a-c per fh g913 3-3-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician November 27, 2010 4a. Facility Name (If not institution, give street and number) 1526 hrs^M /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Center Cheverly Prince Georges 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1XM 2 F 74 Yrs. Director 579-50-2046 June 7,1936 Washington, D.C. Usual Residence of Deceden death with the Maryland 10a. State r than "naturel; or items 23a or 28a-f show the Modical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Director District of Columbia Washington 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 5000 Nannie Helen Burroughs Avenue, N. E. 20019 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygisine. Importent: If Item 27 ie marked other than "naturei", or lier eny injury or other traumatic event. Ite Medical Examirat once. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th grade Brickmason Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unknown) **Kelly** Alberta 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Attorney Ronald Dixon (Guardian) 1010 Cameron Street; Alexandria, Virginia 22314 20b. Place of Disposition (Name of unit cemetery, crematory or other place) Date unk 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Riverdale Pk. CEEDatory 5-5-11 Riverdale, Md. Washington, Dc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility $R.\ N.\ Horton\ Company\ Morticians,$ 21. Signature of Funeral Service Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to irrimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a as the burial-transit The law requires that the death certificate be execu Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ል been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA 2 1 Tyes this 27. Manner of Deat 28a. Date of fnjury (Month, Day Year) Certification: 8b. Time of 28c. Injury at Work? Aller 28d. Describe how injury occurred 1 Netural 2 Accident death. М investigation 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide hours within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number D 273 dress of person who completed cause of death (Item 23a) (Type, Print) Ophnell Cumberbatch, M.D.; 3001 Hospital Drive; Cheverly, Maryland 20785 31. Date filed (Month, Day, Year) 32. Pagiatrar's Signature State MAR 0 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Barden Nathanael 8:25 a M December 2010 Medical 4a. Facility Name (if not institution, give street and number) 3155 Hawks Hill Lane **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Keedysville Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days Georgia 256-62-1009 **Director** 1943 67 May Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Keedysville Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3155 Hawks Hill Lane 21756 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 and 2 should e filed within 72 hours after deal of Health and Mental Hygiene. item 27 is mar-ed other than "natural", or iter other traumatic event, the Medical Examinen: Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should e filed within and Mental Hygiene 7 is maried other th 12 Merchandise Receiver Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hubert Quaye Barden Carrie Tabor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Vicki A. Barden 3155 Hawks Hill Lane Keedysville, MD 21756 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗋 Donation 5 🗀 Other (Specify) Beaver Creek Cemetery 01-05-2011 Hagerstown, Maryland 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1. En er the disease, or complicitions the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one takes a leach line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) ta Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the hed P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an sate has page 2 s autopsy perform death? this certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Oertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Januar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kernein

Registrar
DHMH 17 Rev 7/2009

State

Johnson

/hom no

JAN 0 4 2011

31. Date filed (Month, Day, Year)

100

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12/26/2010 Day ETHEL LEE PARKER 1:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F Hours 03/07/1928 Director 82 276-24-7208 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12627 Layhill Road, #102 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. 0 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" Specify: 3 X Widowed 4 Divorced Black Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11+h Department Store Elevator Operator and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Walter Laney Josabell Rewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12627 Layhill Road, #102, Silver Spring, MD 20906 Department of Health Important: If item 27 Myra Lan Parker/daughter injury or other 20b. Place of Disposition (Name of cemeter) crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State M Burial 2 Cremation 3 Removal from State George Washington Cm | 01/17/11 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Snowden Funeral Home 'n 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Records, HTN 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pneumonitis page o the Hospital or Attending Physician: The lowthin 24 hours after death.

To the Funeral Director: After this certificate he completed filled in by the funeral director, page CHF - diastolic dysfunction performed? Yes 2X No 2 🗆 No 1 Tes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 2 X No 은 1 Tes 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 X Other (Specify) hospice 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours aft Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗷 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29d. Date signed (Month, Day, Year) R143201

Year

Registrar DHMH 17 Rev 7/2009

State

Deborah Miller, CRNP

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

6-01 Muncaster Mill Road, Rockville, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death December 31 Physician 2010 0: aron /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 X M 2 □ F 215-51-9506 25,1998 Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland | Washington County Director Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 13226 Club Rd. 21.742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 K If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Student School 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h William Randall Russell, Sr. Janie Boss Russell ages 1 and 2 should bent of Health and Mentate It. If item 27 is marked ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William R. Russell, Sr.-father 13226 Club Rd. Hagerstown, MD 21742 injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Smithsburg Crematory 1-6-2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) 1331 Eastern Blvd. North Hagerstown. Approximate Interval Between Onset and Death steosarcom Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) ed by the at detached f 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 2 No 2 No 1 Yes 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 2 No 3 🗆 DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 1 Tes မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: I or Attending P after death. Director: After t 1 Natural Injury 5 Pending investigation 1 Tes 2 🗆 No 2 Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de

To the Funeral Director

Completely filled in by the determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ecem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

Registrar

State

31. Date filed (Month, Day, Year)

JAN 0 5

⊯egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201 6:01PM <u> Hazel May White</u> December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Baltimore Towson Greater Baltimore Medical 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🎦 F Days Months Hours Min sept 11,1927 Pennsylvania Director 212-24-1300 83 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21795 USA 10613 Harry Heth Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Baltimore, Maryland 21215-00 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Health and Mental Hygiene. tem 27 is marked other than other tran other tranmatic event, the Me life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Switchboard Operator Utility Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ William Alfred Borror Bernice Elizabeth Crites 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman O. White - Husband 10613 Harry Heth Road Williamsport, MD 21795 Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory Jan.1,2011 |Hagerstown,Maryland 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Funeral Sections 425 S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): 15:5 or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Sarcoma Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subsete \text{No} \) Day Month Year 5 Other (specify) 1 Yes 2 Unknown the should be detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1- Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and the eaun 2010 and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Baltimore, MD 6701 IBEANU 04 State Registrar

DHMH 17 Rev 7/2009

lest Albert Thomas 10-09628 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day December 14, 2010 Medical Examiner 0645 hrs Robert Albert Thomas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rear of 100 E. Baltimore Street and Grant Alley **Baltimore** 5. Social Security Numberink **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk Director Months Days Hours 69 Dec 18, 1940 1 X M 2 F Country) Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant. If tiem 27 is marked other than "natural", or items 23a or 28a-f shor other trainastic event, the Medical Ex miner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 S. Bond St. 21201 USA 11. Marital Status Unk Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 No Specify: White 4 Divorced If Yes, Give Year Yes 2 No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 unk unk 17. Father's Name (First, Middle, Last) Unk 18.Mother's Name (First, Middle, Maiden Surname) UIIK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traumatic 900 W. Baltimore St; Baltimore, MD 21223 O.C.M.E. Baltimore, N permit. Pages 1 and Department of Healtl 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Important: If 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Specify: in state 21. 1 e of Funeral ce License Ronald S 22. Name and Address of Facility State Anatomy Boar rector 655 W. Baltimore St; Baltimore, MD 21201 art I. Enter the disease, or commiscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval mure. List only one cause on each line /Medical Between Onset and Alcohol Intoxication Complicated by Hypothermia Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ed for use as the bunal - trar Physician/Medical 23a,pt.II,27,28a-f per me g913 3-14-11 vt X UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? \$ Atherosclerotic Cardiovascular Disease, Chronic 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a Was an Alcoholism 24b. Were autopsy findings available autopsy prior to completion of cause of has certificate ✓ Yes 2 No 2 No 1 Yes the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 this Other Nursing Home 5 Residence 6 🗹 Other: Scene Inpatient 2 ER/Outpatient 3 DOA ၉ 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural subject ingested alcohol and within 24 hours after death. To the Funeral Director: Pending 1 Yes 2 X No fd 12-14-10|fd 6:43am was exposed to cold 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) rear of 100 E. Baltimore St. and Grant Alley 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined (Specify) Homicide in alley 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated g 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 14, 2010 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registra DHMH 17 Rev 1/2001 **ORIGINAL**

Juno Han Lee 10-08501 Ple

UNK UNK		1- For State Registrar	State of Marylan		artment of <i>rtificate of</i>		nd Me	ental Hy	giene R	eg. No. 2010	43205
Physiciai Medical Examin		Decedent's Name (First, Mid	Jung Han	Lee				1	2. Date of Dea Month Novembe	Day Year	3. Time of Death 1508 hrs
7		4a. Facility Name (if not institu Assateague Island F	tion, give street and numb		4	b. City, Town, o	r Locatio	on of Death	Novembe	4c. County of De Worcester	_ Lath
Funeral		5. Social Security Number		Age (In yrs.	last birthday)	If Under 1 Ye	ar If U	nder 24Hrs.	8. Date of Bir	th(MM/DD/YYYY) 9.	
Director		218-06-5766	1 X M 2 F	36	5 Yrs.	Months Da	ys Ho	ours Min.	May		eign Country) Korea
any		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City	, Town or Locati	on					10d. Inside City Limits
Maryland 28a-f show any d at once.	ģ		ntgomery				ilve	r Spri			1 Yes 2 X No
he Mary or 28a	Director	10e. Street and Number 13168 Broad	more Road			10f. Zip Code	20	904]1	0g. Citizen of What Co	S.A.
th with 1	unera	11. Marital Status 1 X Never Married 2	12. Was Decede			Decedent of Hi es, specify Cuba	spanic (Origin? (Spe			erican Indian, Black,
11215-0036 Ide filted within 72 hours after death with the Maryland Aental Hygiene. narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	ᄔᅵ		1 Yes	2 X No		Yes 2 X No			ican, etc.)	Specify:	Asian
hours at natural	ed b	15. Decedent's Education (Sp			16a. Decedent	's Usual Occupa	ition (Gi	ve kind of wo		16b. Kind of Busines	
D36 thin 72 ne. than "	Complete	Elementary/Secondary (0-12	2) College (1-4 o	or 5+)		inancial			•	Governmen	t Contracts
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Midd							First, Middle, N	Maiden Surname)	t constacts
212' ould be I Menta	lo Be	19a. Informant's Name/Relation	hong Chen Lenship (Type, Print)	ee	19b. Mailing	Address (Stre	et and N	lumber or Ru		Hwan Cho nber, City or Town, Sta	ate, Zip Code)
MD and 2 sho salth and tem 27 is	-1	Jung Eun Lee 20a. Method of Disposition	- Sister	Look	13168	Broadmo	re i	Road,	Silver	Spring, M	D 20904
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: Uritem 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremati		State	Place of Disposit	er place)			Date	20c. Location - City	
Baltin permit. P Departme Importan injury or	ł	4 Donation 5 Other 21 Signature of Funeral Service	Specify: te Licensee	Tra.	22. Na	ame and Addres	s of Fac	ility Hine	14/2011 s-Rina	Breniwood ldi Funera	l, Maryland l Home, Inc.
ம் ஐத்த்தி Physician	1	23a. Part I. Enter the disease, of	2	ed the death	1118	00 New 1	Hamp	shire	Ave.	Silver Spr	ing, MD 20904
Examiner	1	failure ast only one caus Immediate Cause (Final diseas	e on each line.			og	00017 0	o our dido or re	oopiiatory arre	out, shook, of ficult	Between Onset and Death
ZAMIME	1	or condition resulting in death)	Due to (or as a cor	nsequence o	f):						
	힐	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus	Due to (or as a cor	sequence o	f):						
ted Insit	E Xall	(Disease or injury that initiated events resulting in death) Last		sequence o	f):				_		
	edical	X UNPENDED	d AMENDED 2	23a,27	,28a-f	per me s	915	5-9-1	1 vt		
ficate be expension of the purial	/ Mec	IF FEMALE: 3b. Was decedent pregnant in	23c. If yes, outo		nancy					23d. Date of delive	
tox 6876 eath certificate eath certificate is attending phy for use as the life in the interval in the interva	Physician/M	past 12 months?	4 Pregnant	at time of de	ath T	al death 3 er (Specify)	Ecto	pic pregnanc	y	Month	Day Year
D. Bo. at the deat by the att ached for	Ĕŀ	Part II. Other significant cond	titions contributing to dea	ath but not re	esulting in the un	derlying cause of	aiven in	Part I.	23e. Did to	bacco use contribute t	o the cause of death?
ires that the signed by d be detack									1 Yes	2 No 3 Pr	obably 4 Unknown
Division of Vital Records, tat or Attending Physician: The law requires fire death. al Director: After this certificate has been signed in by the funeral director, page 2 should be artification. To Reformulated									24a. Was a	sy prior to	autopsy findings available completion of cause of
tal Reccian: The certificate ector, page		25. Was case referred to medic	al			26 Place	of Deal	th (Check onl	perform		
ision of Vital Israeling Physician: or death. ector: After this certif by the funeral director,	۱۵	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpat		ER/Outpatient		Other ₄	Nursing F		Residence 6 🗸 Oth	er: Scene
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Division of ospital or Attending hours after death. uneral Director: Aft y filled in by the fune.	<u> </u>	2 Accident Inve	estigation	6-10 Injury - At ho	3:08; ome, farm, street	om			f. Location (S		Rural Route Number, City
y fill bou	٦ ٢	4 Homicide dete	ermined (Specify)		of water						
Division To the Hospital or Attention 24 hours after death To the Funeral Director: completely filled in by the Madical Certification	ם פ	(Check only	Physician: To the best of raminer: On the basis of ex aminer and manner stated	amination ar							
E NE S		29b. Signature and title of certification	er			29c. Licens		er		29d. Date signed (M	
	-	30. Name and address of person	of Theel	death (Hom	23a\	O.C.I	И.Е. 	· ·		November 7, 20)10
		Margarita Korell MD.	Assistant Medica	•	er 111 Pe	nn Street, Ba	altimo	re, MD 21	201		
State Registra	e ⁽	31. Date filed (Month, Day Year MAR 0 6 2	32. Registr	ar's Sigratu	re barker	1.					

10-08632		Black Indelible Ink. Ensure <i>i</i>	All Copies Are Leg	ible.
UNK UNK	1- For State	d / Department of Health and i Certificate of Death		2010 43206
Physician/			2. Date of Death	Day Year 1200 bro
Medical Examine	Hermogenes Acevedo 4a. Facility Name (if not institution, give street and numb	er) 4b. City, Town, or Lor	Month November	1200 hrs 4c. County of Death
	300 Arundel Corp. Road	Glen Burnie		Anne Arundel
Funeral Director	Unavailable X M 2 F	Age (In yrs. last birthday) 4 4 Yrs. If Under 1 Year Months Days	If Under 24Hrs. 8. Date of Birth Hours Min. 02/21	(MM/DD/YYYY) 9. Birthplace (State or Foreign PR Country)
and show any nee.	Usual Residence of Decedent 10a. State 10b. County Baltimore 10b. County 1	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 X Yes 2 No
tith the Maryland 23a or 28a-f show notified at once. al Director	10e. Street and Number 617 South Lehigh Stre	et 21224	10	g. Citizen of What Country? USA
s after death w rral", or items ningr must be by Funer	11. Marital Status 1 Never Married 2 Married Armed Force 3 Widowed 4 X X Divorced If Yes, Give Year or Dates:	If Yes, specify Cuban, M	, ,	Specify:
5-0036 ed within 72 hours at tygiene. other than "natural the Medical Examin	15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12) 10 yrs College (1-4 of Elementary/Secondary (0-12)	during most of working life. Do Auto Body Wo	ONOT use retired) Orker	16b. Kind of Business/Industry Automotive
1215-C d be filed v ental Hygi arked oth vvent, the J	David Acevedo		Mother's Name (First, Middle, M Monserrate	Seda
MD 21 nd 2 should alth and Me m 27 is ma aumatic ev	19a. Informant's Name/Relationship (Type, Print) Edith Acevedo Siste	r 617 South Leb	high St Balt:	er, City or Town, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical To Be Complet	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify:	Actancia Crem	03/03/11	20c. Location - City or Town, State Glen Burnie MD
Balt permit Depart Impor	21. Signature of Fugeral Service Licensee			y Crem A Fun Serv dgeRd Hanover MD
Physician /Medical xaminer	23a. Part I, Enter the disease, or complications that caus failure. List only one cause on each line. Immediate Cause (Final disease a. Smoke Inhala	ed the death. Do not enter the mode of dying, suction and Thermal Injuries	ch as cardiac or respiratory arres	st, shock, or heart Approximate Interval Between Onset and Death
Adminier	or condition resulting in death) Due to (or as a consequentially list conditions,	nsequence of):		
at xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
8 9 11	events resulting in death) Last Due to (or as a cond.	nsequence of):		
0, be execute sician and ourial - tran	UNPENDED			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transledical Certification: To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months?	at time of 5 Other (Specify)	Ectopic pregnancy	23d. Date of delivery Month Day Year
P.O. es that the igned by to detache	Part II. Other significant conditions contributing to de	ath but not resulting in the underlying cause give	en in Part I. 23e. Did tob	acco use contribute to the cause of death? 2 No 3 Probably 4 ✔ Unknown
Division of Vital Records, P.O. Box tal or Attending Physician: The law requires that the death rs after death. al Director: After this certificate has been signed by the atte led in by the funeral director, page 2 should be detached for usrtification: To Be Completed by Physic			24a. Was ar autops perform	prior to completion of cause of death?
al Re an: The prtificat tor, pag e Co	25. Was case referred to medical	26.Place of	Death (Check only one)	No 1 Yes 2 No
Vita hysicis this ce al direc	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpa	otient 2 ER/Outpatient 3 DOA Oth	Nursing Home 5 F	desidence 6 🗸 Other: Scene
ion of ' lending Ph eath. or: After t the funeral	27. Manner of Death 1 Natural 5 Pending Pending Nov 10, 20	y,Year) FOUND: 1 Yes	at Work? 2 No 28d. Describe he Building fire	ow injury occurred
Division of Vital I the Hospital or Attending Physician: hin 24 hours after death. The Funeral Director: After this certifipatiety filled in by the funeral director, and the funeral director.	3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm, street, factory, office build acant Building	or Town, Sta	reet and Number or Rural Route Number, City ate) orp. Road, Glen Burnie, MD
To the Hosy within 24 he To the Fun completely it		my knowledge, death occurred at the time, date a xamination and/or investigation, in my opinion, de d.		
	29b. Signature and title of certifier	29c. License nu O.C.M.E		29d. Date signed (Month, Day, Year) November 11, 2010
DV	* *** *** *** *** *** ***	Examiner 900 W. Baltimore Street,	, Baltimore, MD 21223	
State Registrar	31. Date filed (Month, Day Year) 32. Reg	rat's Signature		
DHMH 17 Rev 1/2001		ORIGINAL		OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 per dr. g916 6/17/11kh State of Maryland / Department of Health and Mental Hygiene 1 - State Registraramend 25 per Dr. g913 3/18/10 examinate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Simone Olivia Garratt Physician/ 26 Simone Olivia 20°10 rett December Medical 07:00 AM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Clinton Prince Georges Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 😿 F Months Hours 3 Dec 26, 2010 Director Mary Land INFANT Usual Residence of Decedent show 10a. State be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits or 28a-f sl notified Prince Georges MD Ft. Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code ed other than "natural", or items 23a o event, the Medical Examiner must be 10g. Citizen of What Country? by Funeral 8356 Indian Head Highway 20744 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 X Never Married 2 Married 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates. Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: black 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumotic. Elementary/Seconday (0-12) INFANT College (1-4 or 5+) IŇFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lydia Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lydia Hayes - mother 8356 Indian Head Hwy; Ft Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) in state 21. Sign turn of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final Environ/ disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day signed by the a d be detached for Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown cate has by page 2 s 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 N prior to completion of cause of death?

1 Yes 2 No this certificate Division of Vital Hospital or Attending Physician; 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Hospital 1 Yes 2X No Other: 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) within 24 hours a To the Funeral D edical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mon 32. State egistrar's Signatur Registrar

10-08547 Lanol Jones

26

Land Jones State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 433								0 43208
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Lanol William Jones, Jr.				2. Date of Deat Month November	Day Year	3. Time of Death 0413 hrs
A Part of the Control		4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center		o. City, Town, or Locatio Salisbury	on of Death	110101111111111111111111111111111111111	4c. County of I	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)			Inder 24Hrs.	8. Date of Birt	th (MM/DD/YYYY)	9. Birthplace (State or
Director		4	Yrs.	Months Days Hou	ours Min.	4-14-	-1969 ^F	Ohio Ohio
any		Usual Residence of Decedent 10a. State						10d. Inside City Limits
yland a-f show	tor	VA ACCOMack Pain						1 Yes X No
with the Maryland ns 23a or 28a-f show be notified at once.	Director	31293 Boggs Road	'	10f. Zip Code 23420		10	ng. Citizen of What	Country?
ath with tems 23 st be no	uneral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	Nas [If Yes	Decedent of Hispanic O	Origin? (Spe	cify Yes or No-		American Indian, Black,
after death	by Fu	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	_	'es 2 X No specif	:	,		Black
2 hours "natur	ted b	15. Decedent's Education (Specify only highest grade completed) 16a. Deced	lent's most	Usual Occupation (Giv t of working life. DO NO	ve kind of wo OT use retire	rk done d)	16b. Kind of Busin	ess/Industry
036 vithin 73 ene. er than Medical	Completed	8th Labor	rei	r Farmh	hand		Labore	r— Farming
9, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once.	Be Co	17. Father's Name (First, Middle, Last) Lanol William Jones Sr.			her's Name (F		laiden Surname)	
21; should b and Men is marl	P	19a. Informant's Name/Relationship (Type, Print) 19b. Mail		ddress (Street and Nu	lumber or Ru	ral Route Numl		
ore, MCss and 2 soft Health at If them 27 Hearth at If them 27 Hearth at If them 27 Hearth at If them 18 Hearth at If a the If a	1	20a. Method of Disposition 20b. Place of Disp	ositio	Boggs Rd on (Name of cemetery,		nter,	VA 234 20c. Location - Cit	
Baltimore, MD 2 permit. Pages 1 and 2 shou Oepartment of Health and M important: If Item 27 is n injury or other traumatic		1 Burial 2 X Cremation 3 Removal from State Director 4 Donation 5 Other Specify:	other T	rematory LLC	11/	22/10	Dover	, DE 19904
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If them 27				ne and Address of Facil		717 W	Div.St	. Dover DE
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Cardiac Arrhythm Immediate Cause (Final disease a. and High Take-Off						Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. and High Take-Off Due to (or as a consequence of):	O	f Right Co	ronary	Arter	у	Death
	<u>.</u>	Sequentially list conditions b	_					
,	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated						
scuted and transit	EX.	events resulting in death) Last Due to (or as a consequence of): d.						
50, tte be executed nysician and e burial - transit	ledical	IX UNPENDED X AMENDED 23a, 27 per m 9,16a, b per IF FEMALE: 23c. If yes, outcome of pregnancy	e f	g913 3-18- n g913 3-3	ll ₁ yt _v	l as r		
Sox 6876 death certificate e attending phy I for use as the I	sician/N	23b. Was decedent pregnant in the past 12 months?	etal c	death 3 Ectop	pic pregnanc	у	23d. Date of deli Month	ivery Day Year
Box 68760, e death certificate be the attending physic of the tree as the burned for use	Physic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 0	Other	(Specify)				
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and upplied filled in by the funeral director, page 2 should be detached for use as the burial - transit.	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the	unde	erlying cause given in P	Part I.			e to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the starter death. The Director: After this certificate has been signed by leid in by the funeral director, page 2 should be detach.	Completed					24a. Was an	24b. Were	e autopsy findings available
tal Recc cian: The lav certificate hat	in S					autopsy perform 1 Yes 2	ned? death	
Vital ysician; his certif	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatier	nt 3	26.Place of Death			esidence 6 0	thor
ing Phy After th	⊢ ⊢	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Network	,	y 28c. Injury at Worl	rk? 28		w injury occurred	ater.
rision r Attencer death rector:	icatio	2 Accident Investigation 28e Place of Injury - At home farm stre	eet, fa	1 Yes 2 actory, office building e		f Location (Str	 reet and Number or	Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director- stely filled in by the	5	4 Homicide determined (Specify)		-stery; omed dentaing, o	010.	or Town, Sta		North North Number, City
To the Hos within 24 h To the Fun	<u> </u>	29a. Certifier Check only Certifying Physician: To the best of my knowledge, death occuone) Wedical Examiner: On the basis of examination and/or/investigations.	urred a	at the time, date and plain my opinion, death or	lace, and due	e to the cause(e time, date ar	s) and manner as s	itated. o the cause(s)
To witin	ğ -	and manner stated. 29b. Signature and title of certifier		29c. License number			29d. Date signed (
	-	30. Name and address of person who completed cause of death (Item 23a)		O.C.M.E.			November 9, 2	<u>2010</u>
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Per		Street, Baltimore, I	MD 2120	1		
Sta Registra		31. Date filed (Month, Day, Year) NAR 1 6 2011 32. Registrar's Signature	1					

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hnny Ramo:	s-Ial		epartment <i>Certificate</i>		nd Mental H	ygiene	2	710	42209
· · · · · · · · ·		Registrar 1. Decedent's Name (First, Middle,Last)	<u> </u>	or Death		2. Date of Dea	eg. No.	OIV	3. Time of Death
Physic Padical Exar						Month		Year	1200 hrs
1		4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	r Location of Death			nty of Death	
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Funera		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday			_		Foreign	place (State or
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ž.		Usual Residence of Decedent 10a. State 10b. County 10c.	. City, Town or L	ocation	<u> </u>				10d. Inside City Limits
ow any	,e	Mil Baltimoro	Baltimor						1 X Yes 2 No
Aaryland 28a-f show	it is	10e. Street and Number	Da I CIIIIOI	10f. Zip Code		11	10g. Citizen of	What Count	rv?
ne Ma or 28	al Director	3214 E Fairmont Ave		21224			Hondu		
with the is 23a	<u>a</u>	11. Marital Status 12. Was Decedent Ever	in U.S. 13	. Was Decedent of H	ispanic Origin? (S		o- 14. R	ace - Americ	an Indian, Black,
leath r	Funeral	1 X Never Married 2 Married Armed Forces?	No	If Yes, specify Cuba			W	/hite, etc.	
after (ŭ .	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	X Yes 2 N	o specify: Hor	nduras	Speci	.,.	spanic
hours		15. Decedent's Education (Specify only highest grade complete	ed) 16a. Dece durir	edent's Usual Occupa ng most of working life			16b. Kind of	Business/In	dustry
36 hin 72 te. than "		Elementary/Secondary (0-12) College (1-4 or 5+)	, n	Mechanic			Body	Shop	
-00; d with /giene ther t	Completed	17. Father's Name (First, Middle, Last)		icenam.ee	18.Mother's Name	(First, Middle,			
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	b Be Comple	G.V.			Yeny Ja	mileth	Ramos	Talave	era
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nore, MD 2 ages 1 and 2 shou nt of Health and N		Yeny Jamileth Ramos/Mother		214 E Fair					
or Heg		20a. Method of Disposition 1 Multiple Properties 1		sposition (Name of co or other place)		Date	20c. Locati	on - City or T	own, State
Page ment tant:	5	4 Donation 5 Other Specify:		eral Cemet	4	3/08/11		duras	
Baltimore, ME permit. Pages 1 and 2 s Department of Health a	mlmi	21. Signature of Funeral Service/Licensee	1	22. Name and Addres	.5 0			Funera	al Home 300
Physicia	_	23a. Part I. Enter the disease, of complications that caused the c	death. Do not en	12th. St.				heart	Approximate Interval
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ox 68760, such certificate be extending physician	Physician/Medi	IF FEMALE: 23c. If yes, outcome of 1 Live birth	pregnancy	Fetal death 3	Ectopic pregna	ancy	23d. Date Mont	e of delivery h Da	ay Year
X 6 th cer	ii use sicia	past 12 months? 1 Yes 2 No 9 Unknown	of 5	Other (Specify)					
BO) he death		Part II. Other significant conditions contributing to death but	not resulting in	the underlying cause	given in Part I	23e Did t	obacco use co	ontribute to th	ne cause of death?
, P.O. B ires that the d signed by the	<u>a</u>		not resulting in	and andenying dadse	given in rait i.	1 Ye			ably 4 🗸 Unknown
cords, law require has been sig	Completed	 				24a. Was	an 24		opsy findings available
COF law r has b							ormed?	death?	empletion of cause of
tal Recision: The	S	25. Was case referred to medical		26 Plac	ce of Death (Check	1 Yes	2 No	1 V Yes	2 No
/ital	o Be Con	examiner? Hospital:	2 ER/Outpa		TOther -	ng Home 5	Residence	6 V Other:	Scene
of \ing Phy	<u> </u>	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending 1 Natural 5 Pending			ury at Work?	28d. Describe		curred	
ion tendir eath.	ation	1 Natural 5 Pending Pround Nov 10, 2010	FOUND 1200 hrs		Yes 2 No	Building fire	9		
ViSi or At filter d	ific	3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm,	street, factory, office	building, etc.				al Route Number, City
Spital	Certification;	4 Homicide determined (Specify) Vacant	t Building			or Town, 300 Arundel	Corp. Road,	Glen Burni	ie, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician of the funeral former of the former of the physician of the funeral former of the physician of t	compretely med in by the ledical Certification	29a. Certifier 1 Certifying Physician: To the best of my kno one) 2 Medical Examiner: On the basis of examinat	-						
To the To the	Medical	and manner stated. 29b. Signature and title of certifier			nse number				th, Day, Year)
2		0 01 12	4.		.M.E.			er 11, 20	
		30. Name and address of person who completed cause of death	(Item 23a)				1		
		Jack Titus MD. Deputy Chief Medical Exam	,	N. Baltimore Str	reet, Baltimore	, MD 21223			
	State		gnature	white.					

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			1 - For Amend Item	as 25,27,28	arylan	nd/Depa per me <i>Cei</i>	artment tificate	,013/ of D	ealth 18/20 eath	MPP6	lental Hy	ygiene Reg. No	201	0	4321
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Medical Examiner			Edward	R		Fo	swle	9			Month /Z	ZO Da	ZOL		7306 M
			4a. Facility Name (if not institution, giv	re street and number)			4b. City, To	own, or L	_ocation o	f Death		4c	. County of E	Death	
-				7 Sex 7. Age	- //		Ba	Hu	nor						
	Funeral Director			1 □ M 2 □ F	7 6	ast birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	Date of Bi (Month, D	ay, Year)		Birthplac Country)	e (State or Foreign
		1	Usual Residence of Decedent				L				1/17/	193	4		MD
	land show	5	10a. State 10b. County		10c. City	y, Town or Lo								10d.	Inside City Limits
	Mary 28a-1 otifie	<u>i</u> .	MD			Balt	imore	3							1 XYes 2 No
	a or	읉	10e. Street and Number				10f. Zip C					10g. Cit	izen of What	Country'	?
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	r iter	른	11. Marital Status	12. Was Decedent E Armed Forces?			Vas Deceder Yes, specify	nt of Hisp / Cuban,	panic Orig Mexican,	in? (Spec	cify Yes or No-	- T	14. Race - A Black, W		Indian,
99	al", c	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【X Divorced	1 X Yes 2 If Yes, Give	No	1	☐ Yes 2∑	No	Specify:					Bla	a le
ŏ	hours natur lical	lete	15. Decedent's I	Year or Dates. Education		16a. Deced	ent's Usual (Occupati	ion			16b V			
25	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	(Specify only highest g. Elementary/Seconday (0-12)	rade completed) College (1-4 or 5	+)	(Give k life, D0	ind of work of NOT use re	done dur	ring most		_	1	ind of Busine		•
7	ygien /gien rer th		8		''	Cert	ified	l Nu	ırsi	ng A	ss	H	Health Care		re
pu	e filec ital H ed ott	To Be	17. Father's Name (First, Middle, Last) Daniel Fowle	r				1	18. Mother		, .				
≅	uld b d Mer mark natic	-		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip											
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Ĩ	Tonjay Evan	•		19b. Mailin 4612	g Address (S Debi	itreet and	d Number 1 Ci l	or Rural	Route Numbe	er, City or Bal	Town, State,	Zip Code	³⁾ 208
ē,	1 and of Heal item 2	- 7	20a, Method of Disposition			lace of Dispos	sition (Name	of			ate		cation - City		
E	Page 1 ment of ant: If it ury or o		1 X Burial 2	Removal from State		emetery, crem OWNSVi			1		3/10		wnsvi		
Baltimore,	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service Licen		10-0					-	-				d FS P
<u> </u>	e a E P P	2	Chilp BWea	Sefee							reet				
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	plications that caused one cause on each line.	the death	n. Do not enter	the mode o	of dying,	such as ca	ardiac or	respiratory ar	rest,			proximate erval Between
	hysician/	9	Immediate Cause (Final disease or condition	Subdu	rat	he	mato	mon	1						set and Death
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	ted Insit	Examiner	Cause (Disease or linjury	Due to (or as a	conseque	erice oij.			(1	VI MED	CALEXAM	INER		
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687	ng ph	Me	IF FEMALE:					_				-			
9 X	attending p	ian/	23b. Was decedent pregnant in the past 12 months?	f pregnan D Fetal	death 3	Ectopic pre	gnancy				2	3d. Date of	delivery		
		Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5	Other (speci	ify)					Month	Day	Year
О	at m		Part II. Other significant conditions of	ontributing to death bu	t not resu	Ilting in the un	derlying cau	se given	in Part I.		23e Did to	phaceo us	e contribute	to the co	use of death?
S,	octation in the law requires that the descriptions been signed by the rector, page 2 should be detached	Ω				_					1				4 🗆 Unknown
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<u> </u>	tifica tor, p		25. Was case referred to medical	 				26 Place	of Death	(Check o		2 X No	1 🗆 1	∕es 2 □	No
	lis cel	일	examiner? 1 1 Yes 2 No	Hospital:	nt 2 🗆 E	R/Outpatient		Other:			e 5 🗆 Resid	lanca 6	Other (Sa	aciful	
5	fter th		27. Manner of Death +X Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	2	28b. Time of injury	28c.	Injury at		28	d. Describe h	ow injury		ecny)	
	tor: A	Certificate:	2 Accident 3 Suicide 6 X Could not be			Unknow		1 🗆 Yes	s 2 X N	0	Jnknow				
DIVISION OT	after of Direction by	G	4 Homicide determined	28e. Place of Injury building, etc. Unknown		ne, farm, stree	t, factory, of	fice		28	f. Location (S City or Tow	n, State)		Rural Rou	te Number,
J Finds	hours neral	ical	29a. Certifier 1 💢 Certifying Phys	ici≥n: To the best of m	v knowled	dae, death oc	cured at the	time. da	ite and nia	ace and	due to the cou	nknov	mannar as a	etated	
DIVISION OF VITAL RECORDS, P.O.	within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Medical	Check 2 Medical Exami	er: On the basis of exa e Practioner: To the be	mination a	and/or investig	ation in my	opinion c	footh accor	irrod at th	atima data a	nd place	and due to the		and manner stated
Ę	To t		29b. Signature and title of certifier	1/2				cense nu					signed (Mor		Year)
			4311	m)		フ	95	32			12	-21-	20	(5)
_	ĺ	-	30. Name and address of person who c	ompleted cause of dea			nt)			_					
	State	. 3	31. Date filed (Month, Day, Year)	32 Rosistron	22 Signature	S 6	Pern	c 8	5.4	Ba	timo	rre	m	Di	10515
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Physicia Medic Examin	al
Funeral Director	

For State Registrar

iral", or items 23a or 28a-f show Examiner must be notified at ier than "natural", < , the Medical Exam

and Mental Hygiene. is marked other than traumatic event,

Baltimore, Maryland 21215-0036 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Carrier Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve once. ပ William Edward King 19a. Informant's Name/Relationship (Type, Print) Joy Shurnitski - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) January Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

5 ☐ Other (specify) ____ IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ Completed has been 24a. Was an autopsy certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient **Director:** After this director in by the funeral director 2 ER/Outpatient 3 DOA Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at work? Natural (Month, Day, Year) 5 Pending hours after death. Accident Suicide Investigation М 1 🔲 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a, Certifier (Check only one 29b. Signature and title of certilie 4 person who completed cause of death (Item 23a) (Type, Print)

Month 58 AM 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washing MI Year Social Security Number 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace State or Foreign 1 🕅 M 2 □ F year) 1927Washington, D.C 578-30-4810 Months Min. March T3. 83 Yrs Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 432 Vermont Avenue 21740 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No ģ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced W.W.II white Specify Year or Dates. 16b. Kind of Business Industry postal service 18. Mother's Name (First, Middle, Maiden Surname) Elsie Christine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 RockWillow Avenue, Hagerstown, Maryland 21740 20c. Location - City or Town, State Hagerstown, Maryland Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 2 A 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? performed?

Yes 2 No 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. egistrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Virginia December 31, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 636 Linganore Ave. Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 TF Director 82 182-22-6471 June 17, 1928 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1XYes 2 ☐ No Director MDWashington Hagerstown 10g. Citizen of What Country? 10e. Street and Number items 23a 11403 Stonecroft Court 21742 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced Year or Dates: White Completed 16b. Kind of Business/Industry or other traumatic event, the Wedical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Publication Typographer permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item Z7 Is marked other any injury or other traumation. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Alter Gipe Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Heishman / Daughter 1041 Carroll Heights Blvd., Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 1/5/2011 Rest Haven Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 10 Years **Physician** disease or condition carcinoma /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 220No certificate 2 No 1 ☐ Yes 1 Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Home Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D68995 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lct, Hagerstown, 2H-2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G912 2/02/2011 JH State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:41AM Mahone 2010 nda 30 Medical Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Bathmore Manuland Medical Center 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. Sep. 21 59 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other trainartic event, the Medical Examiner must be notified at any injury or other trainartic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12334 Walnut Point West 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Driver Trucking Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James William Kirby Claudeine Henrietta Long Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12334 Walnut Point West Hagerstown, MD 21740 James R. Mahone, Jr.-husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park: 1-4-2011 Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pencreatitis Physician/ disease or condition resulting in death) Necrotizine Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Dav ☐ Pregnant at time of death☐ Unknown 9 Unknown signed by t if be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy death? certificate l 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 Impatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural work? 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/30/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland Universita State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

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IK UN	K		State of Maryland / Department of Certificate of Ce			Reg. No. 2010	43214
	hysicia Exami		Registrar 1. Decedent's Name (First, Middle,Last) JAMAL M. WILLIAMS		Date of Dea Month October 2	ath Day Year	3. Time of Death 0742 hrs
\frac{1}{2}			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
F	uneral		3362 Curtis Drive Apt. T3 5. Social Security Number	Suitland If Under 1 Year If Under 24Hrs	. 8. Date of B	irth (MM/DD/YYYY) 9. Bi	rthplace (State or
	irector		578-15-7000 1 M 2 F 27 Y	Months Days Hours Min	6/21/	/1983 Forei	gn ountry) MARYLAND
	any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation	<u> </u>		10d. Inside City Limits
land	f show	tor	MD PRINCE GEORGE'S HILLCREST				1 X Yes 2 No
Mary	or 28a fied at	Director	10e. Street and Number 3314 CURTIS DR.	10f. Zip Code 20746	1	10g. Citizen of What Co. JNITED STATE	•
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Her deal	l", or it		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:		Specify: BLA	ACK
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15-0 fled	al Hygic ced othe nt, the D	Be Co	17. Father's Name (First, Middle, Last) LARRY H.WILLIAMS	18.Mother's Name GAIL JC		Maiden Surname)	
D 212	Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ToE		ng Address (Street and Number or F		mber, City or Town, State MD., 20746	e, Zip Code)
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Ball	Depart Impor injury			Name and Address of Facility CAF 425 MARYLAND AVE.			DC 20002
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l Re	rtificate or, page		25. Was case referred to medical	26.Place of Death (Check	لنشا	2 No 1 Y	es 2 No
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ivisi	ours after death teral Director: filled in by the	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.		(Street and Number or R	
Division of Vital Records, P.O. Box 68760,	within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide a part to 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	urred at the time, date and place, and	IT3, Sur I due to the cau	use(s) and manner as sta	ted.
Tothe	within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investignand manner stated. 29b. Signature and title of certifier	ation, in my opinion, death occurred a	at the time, date	e and place, and due to to	
		-	10-10-	O.C.M.E.		October 24, 201	
			30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 11	1 Penn Street, Baltimore, M	D 21201	<u> </u>	
	S	ate	Ot Day State of Circolus				

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ORIGINAL

			State of Maryland / Dep 1 - State Amend Item 25 per me, g914,04/05	artment of Health and N 12011dhb I tilicate of Death	Mental Hy	giene Reg. No. 2010 43215
	Physici				2. Date of De Month	ath Day Year 3. Time of Death
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	if Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Pate of Birt (Mgnth, Da	th y Year) 9. Buthplace (State of Oreign Country)
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	e Maryla ta-f shor	Director	to only to the control of			10d. Inside City Limits 1 ☐ Yes 2 No
	with the	I Dire	10e. Street and Number 3227 Bel Pre Road	10f. Zip Code 20906		10g. Citizen of What Country?
36	in 72 hours after death with the Maryland "natural", or items 23a or 28a-f show ledical Examiner is ust be notified at	by Funeral	11. Marital Status 1	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:	pecify Yes or No Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White
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_	is 1 and 2 should b of Health and Ment item 27 Is marked other traumatic e			ng Address <i>(Street and Number or Rui</i> ingfisher Way, Den		
galtimore,	8 ± ± 8		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition 4 □ Donation 5 □ Other (Specify) 20c. Place of Disposition Cremation Cremation	matory or other place)	Date2010	20c. Location - City or Town, State
Baltı	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service Licensee 2:		elvin T.	Alexandria, VA Strider Co., Inc. WV 25414
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ecords, P	ding Physician: The law requires that the de h. After this certificate has been signed by the funeral director, page 2 should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		obacco use contribute to the cause of death? Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
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5	hysicia this cert	To B	examiner? 1 X Yes 2 ER/Outpatier 2 ER/Outpatier	26. Place of Death		ne) lence 6 ☐ Other (Specify)
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	tal or Atters after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	eet, factory, office	28f. Location (S City or Town	treet and Number or Rural Route Number, rn, State)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr	edical	29a. Certifier (Chack only one) 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the o	cause(s) and manner as stated. date and place, and due to the cause(s)
	Tor	Σ	29b. Signature and title of certifier Authora I lan offor D.	29c. License number H 6 76 24	2	29d. Date signed (Month, Day, Year)
	9		30. Name and address of person who completed cause of death (Item 23a) (Type, I 3227 Bel Pre Rd. Silve	r Spring, n	0 2	0906
	Stat Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, I 32. 7 Bel Fre Fel. Silve 31. Date filed (Month, Day, Year) DEC 0 3 2010 Shows A. A	park		

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	Exami			Memorial H				Fr	ederi	ck		4c. (County of Death Freder	ick	
	Funeral Director		5. Social Security Number 073-14-7368 Usual Residence of Decedent	5. Sex 1 □ M 2 X F	Age (In yrs.	last birthday) 88 Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Bi (Month, Di 12/0	rth a <i>y, Year)</i> 6/192:	9. Birth Cour	place (State or Foreign htry) New York	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County	10c. City, Town or Lo			F 10f. Zip	Frederick					10d. Inside City Limits 1 🛣 Yes 2 □ No 0g. Citizen of What Country? USA		
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Baltimore,	t. Page tment c rtant: If rjury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Sp	ecify)	te Mt.	cemetery, crem Lebanc	on Ce	ther place mete	ry 1		3/2010	Ad	ation - City or To		
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). Box 68760		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	2 Fet at time of	al death 3 🗌	Ectopic p Other (sp					23	d. Date of delive Month	ery Day Y ear	
Records, P.O.	s been signed the should be detailed.											Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 If Unknown			
		Completed by									24a. Was autor perfo	psy ormed?	24b. Were autor prior to cor death? 1 Yes	osy findings available inpletion of cause of	
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the Hosp	within 24 hours a To the Funeral C	Medical	(Check 2 ☐ Medical Exa only one) 3 ☐ Certifying N	nysician: To the best of miner: On the basis of urse Practioner: To th	examination	n and/or investig	gation, in neath occur	ny opinion red at the	, death occu time, date an	rred at th	e time, date a	and place, ar	nd due to the cau	ise(s) and manner stated	
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DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar amend 15,16ab,19ab,24a,30 peredificates po Des 10/10 kh Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 3. Time of Death Physician/ 30AM Medical ty Name (if not institution, give street and number **Examiner** City, Town, or Location of Death ounty of Death timore Himore **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) Director items 23a or 28a-f show event, the Medical Examiner must be notified at 10c City Town or Location **Funeral Director** 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ō Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No Yes 1 Yes 2 No If Yes, Give Year or Dates. "natural", 3 Widowed 4 Divorced Islan Indian 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than, /Seconday (0-12) College (1-4 or 5+) Ò and Mental Hygiers infant infant Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 2 traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sarabjeet Kaur 200 Brushwood Dr. Owings Mills 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 □ Donation 5 N Other (Specify) 1+050 ITAL 112/10 tospitA Signature of Funeral Service Licensee 1150000 L 22. Name and Address of Facility 51 NA 2401 W. Delvibere Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) burial-transit resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
 5 Other (specify) Pregnant at time of death Month Day 1 Yes 2 9 Unknown signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifice Be 25. Was case referred to medical the funeral director. 26. Place of Death (Check only one) Hospital Other: ည 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 28h. Time of 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 - Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave. Baltimore, 21215 31. Date filed (Month, Day, Year, NEC 10 OD State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM/8 Perfil, 6927,5/16/2012, WS

State of Maryland / Department of Health and Mental Hygiene

1- State Amend Items 25,27,28a-f per me, g915,05/06/2011dhb

Reg. No. 2010 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wendell Burroughs Fowler, Jr. December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's aurel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birthan. 3,1954. Birthplace (State or Foreign 1**x** M 2 □ F (Month, Day, Year) Country)
Washington Director 577-74-2229 Yrs. 56 Usual Residence of Decedent 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD 1 Tes 2 XNo Prince George's Laurel ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 14200 Laurel Park Drive 20707 USA Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2XX No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or δ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Wildowed 4 Divorced White Year or Dates er than "natur, 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 27 is marked other in traumatic event, the 12th Interior/Exterior Painter Painting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wendell Burroughs Fowler, Sr. Mary Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Richard A. Fowler / Son 27134 Erin Drive, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 12/29/2010 Odenton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. Þ M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ligart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Septic Onset and Death Physician/ Shock disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Decubitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hypoxia attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Acute Respiratory IF FEMALE CERTIFICAT 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Year the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Quadriplegia Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 2 100 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Year) Natural 03/1983 5 Pending n 24 hours after death.

• Funeral Director: Af pleted filled in by the fu **Unknown**_M Subject was shot 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Unknown 28f. Location (Street and Number or Rural Route Number, determined Washington, DC Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check To the within 2 29b. Signature and title of certifier 29c. License number 12962 Doo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital LLACER M.D. 7300 Van MD 20707 EE 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28 Maryland Deportment of Health and Mental Hygiene Certificate of Death Reg. No. Reg. No. 2010 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year

Physician Day Month JASON KEENE Ą /Medical Dec 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BRINTON WOODS-FRANKFORD NULL BATIMORE
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2-5-19 **Funeral** Hours 1 **3** M 2 ☐ F Days Min. 38 Director 216-33-7798 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ir then "naturel", or items 23e or 28e-f show The Mudical Examinar must be notified at WD BALTIMORE CITY Director BRINTON WOODS- FRANKFORD NURSING HOME 10e. Street and Number 10f. Zip Code 5009 FRANKTORD JUNJVA 21206 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working iffe. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If item 27 is marked oth eny jury or other treumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) RUSSELL KEENE BARBARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lather 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) weenmount 12-17-2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F. H. crette 11016. North 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician FALURE TO THRIVE /Medical Due to (or as a consequence of): Examiner ANOXIC MANJURY BRAN Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dualto (or as a consecuence of) W PROVED BY TE BIRTH Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Aspiration premmonta CONTRACTURES 24a. Was an autopsy performed? of Vital 1 ☐ Yes 2 **X** No or Attending Physicien: 25. Was case referred to medical exeminer?
1 Yes 2 No Medicai Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Division 5 Pending investigation → Natural nours after death, nerel Director: Aft filled in by the fun **Unknown** M 1 ☐ Yes 2 X No Unknown Unknown 2 Accident 3 🗌 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Unknown New Jersey within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number Kradugam D0070832 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J3MMAHOM KIDDUGAVU

2010 2:10 4c. County of Death BALTIMORE CITY Birthplace (State or Foreign Country) 10d. Inside City Limits 1 Yes 2 ☐ No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry KEENE Ba HO MD 21205 20c. Location - City or Town, State Balto, MD Avenue Balto, MD 21202 6 months Dr. Tihis 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🕻 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) Dec 06, 2010 821 N EUTAW St # 308 BOTIMBLE

3. Time of Death

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 29, Day 2010 Year Rov Lavanda Batten 11:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery Hospice Casey House Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth 229 92 3393 1 XM 2 D F Months Days Aug:8 1968 Director Yrs. VIRGINIA Usual Residence of Decedent Town or Location Cedar Ave 28a-f shov 10a. State the Medical Examiner must be notified at Director Prince George 10d. Inside City Limits 608 MD 1 X Yes 2 □ No FORT WASHINGTON, MD 20744 10e. Street and Numbe 5 10g. Citizen of What Country? items 23a Funeral U.S.A. 608 CEDAR AVE 20744 Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 □ No If Yes, Give Year or Dates.1986 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) STUDENT COLLEGE injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ N/A MARIE ALMA BATTEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIE B.ARTIS (Mother) 12217 Smithneck Rd. Carrollton, Va. 23314 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or otl
once, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) CARROLLTON, VA. 23314 4 Donation 5 Other (Specify) July 7 201 Macedona Chur.Cemty. 22. Name and Address of Facility 4308 Suitland Rd. Suitland, MD Signature of Funeral Service Licensee Marshall,s Funeral Home 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Pregnant at time of death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 YOther (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 🖟 crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29d. Date signed (Nonth, Day, Year) asus

Registrar
DHMH 17 Rev 7/2009

State

(CMI) 10 Center Drive, Bethesda, Maryland

NIH

20892

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me, 9917,07/15/2011dnb,23a Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ J. Month AM N+90 Medical 4a. Facility Name (if not institution, give street and humber, **Examiner** City, Town, or Location of Death 4c. County of Death en 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Months Hours Mary Land NOV 79 Director Yrs. Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Ves 2 No ti Mo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a (Funeral 1100 21215 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Black, White, etc. Completed by 2 1000 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3
Widowed 4 Divorced Blac Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname, ဂ္ 5 e Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rie KWa lav Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service Licens, e 22. Name and Address of acility Saltimou 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval.Between Immediate Cause (Final Hysician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events southing indeet). Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transi 0 been signed by the attending physician and Due to/(or as a consequence of): resulting in death) Last IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery be detached for in the past 12 months? Month Day Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 24 No Hospital: မ Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 X Accident Year 5 Pending work? 10/2009 Subject fell. Investigation **Unknown**^M 2 **X** No 1 Tes 6 Could not be Suicide Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Poute Number, City of Town, State) Baltimore City, Maryland determined hours after within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) larne and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month,

Day Year)

rack

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Amend Items 25,27,28a-f per me,g918,08/31/2011dhb Registrar Registrar 2010 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RUFF 09:56 AM MARC 9010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEMORI MORE Social Security Numbe . Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex, 1.20 M 2 □ F (Month, Day, Year Months Days Hours Min. 216 98 31560 MO Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director MO 1 Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code r items 23a or ner must be n ō 10g. Citizen of What Country? Funeral RUTLAND 21213 SA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLAC "natural", 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROACH NOA MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1💢 Burial 2 🗌 Cremation 3 🔲 Removal from State OAKLAWN CEMETARY 4 Donation 5 Other (Specify) 3altimore MD . Signature of Fun al Sevia Licensee FNRL 22. Name and Address of Facility HAVISSR AVE OD s, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Enter the dise Approximate Interval Between Onset and Death shock, or heart fail Immediate Cause (Fina Due / Physician/ disease or condition resulting in death) WOOK Medical (or as a consequence of) **Examiner** year Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury HOWARDON To the Hospital or Attending Physician: The law requires that the death certificate be executed ON ars use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXP signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy perforn Io the nocernal within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) X Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? Natural Subject was shot 10:56p M 2 🗶 No 11/28/2007 Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **1400 Block Orleans** 4 X Homicide determined Street Found: Street, Baltimore, MD Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

lange

la 31. Date filed (Month, Day, Year,

AUG 3 1 2011

Registrar's Signature

Memoria

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend 21 per FH G937 3/13/13 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles H. Whittum Jr. 20Î0 13:39 P M June Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of MD Medical Center Baltimore 5. Social Security Number . Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 80 **Director** 204-22-1374 Country) 1**X** M 2 □ F Vrs 10/30/1929 Usual Residence of Decedent GA 23a or 28a-f show 10b. County item 27 Is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Talbot Bozman 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21612 7300 Quaker Neck Road permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 ☐ Never Married 2 😾 Married 3altimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ CEO Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Margaret Oberby Charles H. Whittum Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P O Box 236, Bozman, MD 21612 Juliana Whittum/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or 6/7/2010 Stevensville, MD Chesapeake Crem. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam John R. Merceron per DVR 200 S. Harrison Street, Easton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Intracranial hemorrhage Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of). use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death g Unknown signed by the at d be detached for 1 Yes 2 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, atrial fibrillation on anticoagulation 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed? Yes 2 X No 2 🗌 No 1 🗌 Yes Division of Vital the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical funeral director. To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🙀 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director; After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred **X**Natural injury 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the Last of the knowledge beth occurred at the time, date and place, and due to th 29b. Sign completed cause of death (Item 23a) (Type, Print) Greene St. Baltimore 3 MM Date filed (Mor State Registrar

DHMH 17 Rev 06-2011